

# BYLAWS OF THE MEDICAL STAFF

SPRINGFIELD HOSPITAL CENTER

SYKESVILLE, MARYLAND

September 2014

# TABLE OF CONTENTS

| SECTION   | PAGE |
|---|------|
| <b>PREAMBLE</b> . . . . .                                 | 3    |
| <b>DEFINITIONS</b> . . . . .                              | 3    |
| <b>ARTICLES</b>   |      |
| I. Name and Overview . . . . .                            | 7    |
| II. Purpose . . . . .                                     | 8    |
| III. Membership Requirements . . . . .                    | 8    |
| IV. Categories of Appointment . . . . .                   | 23   |
| V. Officers and Committees . . . . .                      | 29   |
| VI. Medical Staff Meetings . . . . .                      | 38   |
| VII. Corrective Actions, Suspensions and Rights of Appeal | 41   |
| VIII. Physician Health . . . . .                          | 43   |
| IX. Immunity From Liability . . . . .                     | 45   |
| X. Additional Provisions. . . . .                         | 46   |
| XI. Amendments and Revisions. . . . .                     | 53   |
| XII. Adoption . . . . .                                   | 53   |
| <b>APPENDICES</b> . . . . .                               | 54   |
| <b>SIGNATURE PAGE</b> . . . . .                           | 62   |

## PREAMBLE

Recognizing that the Medical Staff is responsible for the medical care and treatment of all patients in this hospital and must accept and assume this responsibility, subject to the ultimate authority of the Behavioral Health Administration (BHA), and that the best interests of all patients are protected by its concerted efforts, operating in a framework within which they can act with a reasonable degree of freedom and confidence, the practicing Licensed Independent Practitioners in Springfield Hospital Center organize themselves in conformity with the Bylaws hereinafter stated.

For the purpose of these Bylaws, the Medical Staff shall be interpreted to include Active, Adjunct and Ancillary Staff who are privileged to attend patients in the Springfield Hospital Center. The use of the term "Member" (with a capital letter) shall denote the category of Active Staff.

## DEFINITIONS

1. **Active Staff** – Any doctor of medicine and surgery or osteopathy holding a current license to practice his or her profession who is credentialed and privileged by the hospital to provide patient care services independently.
2. **Adjunct Staff** - Licensed Independent Practitioners including, Dentists, Optometrists, Audiologists, Podiatrists and Physicians who are not active Members, but hold a current license to practice his or her profession, and are credentialed and privileged by the hospital to provide patient care services independently.
  - a. **Adjunct Staff (Audiologists)** - An Audiologist is a professional who diagnoses, treats, and manages individuals with hearing loss or balance problems. They are not Members of the Medical Staff. They may not admit patients to the hospital and they may not vote, hold office, serve on committees or pay dues.
  - b. **Adjunct Staff (Dentists)** - A Dentist is a doctor of dental surgery or dental medicine who is licensed to practice dentistry by the State (Maryland) Board of Dental Examiners pursuant to Maryland Annotated Code Health Occupations Article 14-101 et seq. Dentists diagnose and treat problems with teeth and tissues in the mouth, along with giving advice and providing preventative care to help prevent future problems. They are not Members of the Medical Staff. They may not admit patients to the hospital and they may not vote, serve on committees, hold office and pay dues.
  - c. **Adjunct Staff (Optometrists)** - An Optometrist is an adjunct staff member who is a licensed, independent practitioner, who has completed the Optometry training from an accredited school and is registered with the State Optometry Board. An Optometrist detects, diagnoses, and treats any optical or diseased conditions in the human eye. Optometrists are not Members of the Medical Staff. They may not admit patients to the hospital, vote, serve on committees, hold office or pay dues.
  - d. **Adjunct Staff (Podiatry)** - A Podiatrist is an adjunct staff member who is licensed to practice podiatry by the State (Maryland) Board of Podiatric Medical

Examiners pursuant to Maryland Annotated Code Health Occupations Article 16-101 et seq. A Podiatrist shall deal with the prevention, diagnosis, treatment and rehabilitation of medical and surgical conditions of the feet and lower limbs. Podiatrists are not Members of the Medical Staff. They may not admit patients to the hospital, vote, serve on committees, hold office or pay dues.

3. **Ancillary Staff** – Individuals who are credentialed and privileged by the hospital to provide patient care services under the supervision of a Member of the Medical Staff.
  - a. **Ancillary Staff (Physician Assistants)** – Refer to Physician Assistant section (4.1.8).
4. **Appointment** – A commitment to extend an offer of employment to a particular candidate. Also used to describe the process of granting Medical Staff Membership and clinical privileges to an independently licensed provider who will be employed by/under contract to the hospital (i.e. Medical Staff appointment).
5. **Associate Clinical Director** – Is an experienced, preferably board-certified psychiatrist Member of the Medical Staff and hospital management team. If not board-certified, the Director will have affirmatively established comparable competence through the credentialing process. He/She is charged with overseeing admissions, transfers, discharges, and the general provision of clinical services within the hospital. In addition, the Associate Clinical Director is responsible for encouraging a cooperative and effective relationship between Medical, other professional staff, and management. Other functions include ensuring effective committee functioning, medical record keeping, and serving as a Clinical Designee for the Clinical Director. The Associate Clinical Director position is one that requires a competitive interview process and responsible to the Clinical Director.
6. **Chief Executive Officer (CEO)** – Is the individual who acts on behalf of the BHA Facilities' Governing Body in the overall management of the facility. The CEO is appointed by the Executive Director of BHA.
7. **Clinical Director and Chairman, Department of Psychiatry and Medicine** - Is an experienced, board-certified psychiatrist and Member of the Medical Staff. The Clinical Director is the individual who assumes overall responsibility for all clinical activities (patient care, teaching and research). The functions include ensuring ongoing compliance of all clinical services with certifying and accrediting agencies and to monitor and improve the performance of all clinical staff. Additional responsibilities include Medical Staff liaison, strategic planning, complex case management, and reviewing Medical Staff appointment, awards and disciplinary action. The Clinical Director is appointed by the CEO.
8. **Clinical Privileges** – Authorization, recommended by Medical Staff Credentials and Executive Committees, approved by the Clinical Director and CEO and granted by the SHC Executive Council to a practitioner to provide specific patient care services.

- 9. Consultants** – Consultants must be qualified, trained and licensed in the specialty field in which the privileges are held. Consultants are not Members of the Medical Staff. They may not admit patients to the Hospital, vote, serve on committees, hold office or pay dues. The consultation shall include examination of the patient, review of the patient's medical record and written statement signed by the consultant and is to be made part of the patient's medical record.
- 10. Department of Psychiatry and Medicine** – The primary organizational structure of the hospital that oversees Medical Staff Member Hospital appointment, quality improvement monitoring, supervision, and discipline. The structure and functioning of the Department and other activities of the Medical Staff are described primarily in the Medical Staff Bylaws.
- 11. Director, Medical Services** – An experienced, preferably board-certified medical specialist Member of the Medical Staff and hospital management team. If not board-certified, the Director will have affirmatively established comparable competence through the credentialing process. She/He is charged with overseeing all Hospital medical, laboratory, pharmacy, radiological, dental and infection control services. In addition, the Director is responsible for reviewing all significant medical morbidity and mortality, encouraging a cooperative and effective relationship between the medical and other professional staff. Other functions include assuring effective committee functioning and medical record keeping. The Medical Services Director is appointed by and responsible to the Clinical Director.
- 12. Licensed Independent Practitioner (LIP)** – An individual permitted by law and by the hospital to provide patient care services without direct clinical supervision within the scope of his/her license, and in accordance with individually granted clinical privileges.
- 13. Medical Staff** – A general term for the organized body of physicians, podiatrists, audiologists, optometrists and dentists, whether employed by the State or under contract, who are hired and granted clinical privileges to serve the medical, psychiatric, and dental needs of Springfield Hospital Center's patients.
- 14. Medical Staff Executive Committee** – Is a committee created by the Medical Staff to serve as the ultimate authority for the structure and function of its governance. Its main functions include leadership, advocacy and development of the staff, as well as performance improvement of all professional services especially those provided by physicians with clinical privileges.
- 15. Member** – Any physician who is appointed to the Active Staff category and who has been granted clinical privileges to practice independently.
- 16. Mental Hygiene Administration (MHA) Facilities' Governing Body** – The MHA Facilities' Governing Body, is the hospital's external Governing Body that has authority and responsibility for establishing operational facility policy, organizational management, continuous quality improvement programs, and facility management and planning for the facilities operated by MHA. The chairperson of the MHA

Facilities' Governing Body is the Executive Director, MHA.

- 17. Physician** – A doctor of medicine and surgery or osteopathy, who is licensed for independent practice by the State (Maryland) Board of Physicians pursuant to Maryland Annotated Code Health Occupations Article 14-101 et seq.
- 18. Primary Care Physicians** – A doctor of medicine and surgery or osteopathy who is licensed for independent practice by the State of Maryland, Board of Physicians pursuant to Maryland Annotated Code Health Occupations Article 13-101 et seq. The practitioner must also provide evidence of necessary background, training, experience, current competence and ability to provide the privileges requested; of adherence to the ethics of the profession; of good reputation; and of ability to work with others well enough to ensure that any patient treated in the Hospital will receive quality medical care.
- 19. President of the Medical Staff** – Is an experienced physician and presides over the Medical Staff meetings and the Medical Executive Committee, overseeing the structure and functioning of the Medical Staff organization. Other functions of the President of the Medical Staff include advocating for the entire Medical Staff and working with the Hospital's leadership to ensure quality medical and psychiatric care. The President of the Medical Staff is elected by the Medical Staff Members who are eligible to vote.
- 20. Psychiatrist on Duty (POD)** – The assigned licensed psychiatrist, who provides coverage to patients after normal working hours, usually but not limited to evenings, nights, weekends and holidays. This physician remains on grounds at all times and is available to render medical and psychiatric services and also functions as admissions officer.
- 21. Somatic Physician on Duty (SPOD)** – SPOD is a primary care licensed physician who provides coverage to patients after normal working hours, usually but not limited to evenings, nights, weekends and holidays. These physicians remain on grounds and are available at all times to render medical and psychiatric services and also function as admissions officer when the Psychiatrist on Duty (POD) is not present.
- 22. Springfield Hospital Center (SHC) Executive Council** – The SHC Executive Council, is the hospital's internal Governing Body that supports and assists the MHA Executive Director in carrying out the powers, duties and delegated responsibilities with regard to the operations and management of the facility. The Chief Executive Officer of SHC is the Chairperson of the SHC Executive Council. The permanent Members of the SHC Executive Council are the Chief Executive Officer, Clinical Director, Chief Operating Officer, President of the Medical Staff and the Directors of the departments of Nursing and Human Resources. The Director of Performance Improvement & Patient Safety is a non-voting ex-officio member.
- 23. State (Maryland) Board of Physicians** - The physician's licensure and disciplinary Board in the Maryland Department of Health and Mental Hygiene (DHMH).

# **ARTICLE I – NAME AND OVERVIEW**

## **1.1 - Name**

The name of this organization is the “Springfield Hospital Center Medical Staff”. This is a single, organized, self-governing Medical Staff that has overall responsibility through the Clinical Director to the CEO for the quality of professional services provided by individuals with clinical privileges.

## **1.2 – Medical Staff**

The Medical Staff includes all licensed physicians, podiatrists, dentists, audiologists, optometrists, physician assistants, nurse practitioners, residents, fellows and students in any of these disciplines as permitted by law and the hospital to provide patient care services independently. All Medical Staff have delineated clinical privileges that define the scope of patient care services that they may provide in the hospital. All Medical Staff Members are subject to the Medical Staff Bylaws, rules, regulations, and hospital policies, and are subject to ongoing review as part of the organization’s performance improvement activities.

## **1.3 – Medical Staff Bylaws**

Medical Staff self-governance is delineated in documents that describe and define how the Medical Staff will organize and govern its affairs. These issues of self-governance are fully delineated in these “Bylaws” which create the standards and structures necessary for the ongoing activities of the Medical Staff. Special emphasis is given to Medical Staff Membership, the credentialing process, and the role of the Medical Staff Executive Committee.

These Bylaws are adopted by the Medical Staff and are revised as needed but at least once every two years to reflect changes in law, rules, regulations, policy, accreditation standards and/or the hospital’s current organization and mission. They are adopted by the Medical Staff and presented to the Clinical Director. The Bylaws are then approved by the CEO and the SHC Executive Council after legal review before becoming effective. Neither the Medical Staff, the Clinical Director, the CEO, nor the SHC Executive Council can unilaterally amend the Medical Staff Bylaws. The Medical Staff Executive Committee or Hospital Administration shall notify the SHC Executive Council in writing of any violation of these Bylaws.

These Bylaws, rules, and regulations create a framework within which Medical Staff Members can act with a reasonable degree of freedom and confidence. These Bylaws include or describe the following:

1. Methods for selecting officers.
2. Qualifications, responsibilities, and tenures of officers.
3. Conditions and mechanisms for removing officers from their positions.

4. Requirements of meeting frequency.
5. Mechanisms to ensure effective communication between the Medical Staff, Clinical Director, the SHC Executive Council, and the BHA Facilities' Governing Body.
6. Mechanisms for amending and adopting the Bylaws.

## **ARTICLE II – PURPOSE**

### **2.1 – Purpose**

The purpose of this organization shall be:

1. To ensure that all patients admitted to SHC receive quality psychiatric and medical care.
2. To provide a means whereby problems of a medical-administrative nature may be identified, discussed and resolved by the Medical Staff with input from the Clinical Director and SHC Executive Council as needed.
3. To initiate and maintain policies and procedures for guiding the clinical, teaching, and research activities of the Medical Staff.
4. To provide quality educational programs and to define and maintain adequate educational standards of the Members.
5. To ensure a high level of professional performance through the appropriate delineation of the clinical privileges that each practitioner may exercise in the hospital and through an ongoing review and evaluation of each practitioner's performance in the hospital.
6. To establish and maintain standards of professional clinical performance, professional ethical conduct, supervision and continuing education for staff and trainees.
7. To provide for and implement a Quality Improvement Plan which includes, but is not limited to, the following components or activities:
  - a. Utilization Review
  - b. Patient Care Monitoring
  - c. Credentialing and Clinical Privileges Evaluation
  - d. Professional Growth and Development
  - e. Facility and Program Evaluation

## **ARTICLE III – MEMBERSHIP REQUIREMENTS**

### **3.1 – Qualifications for Membership**

3.1.1 – Applicants for Membership to the Medical Staff shall be the following LIPs: medical physician, osteopathic physician, dentist, podiatrist, audiologist, and optometrist. These LIPs must be a graduate of approved and recognized schools and be legally licensed to practice in his/her profession in the State of Maryland.

3.1.2 – No applicant shall be denied Membership on the basis of race, religion, gender,



national origin, handicap or any criteria lacking professional justification.

## **3.2 – Ethics and Ethical Relationships**

Principles of medical ethics, as adopted or amended by the American Medical, the American Psychiatric and the American Dental Associations, the State Board of Physicians, Board of Examiners of Podiatric Medicine and the Dental Board shall govern the professional conduct of the Members of the Medical Staff. For example, all Members of the Medical Staff shall pledge themselves to not receive from, nor pay to, another LIP, either directly or indirectly, any part of a fee received for professional services. In addition, there shall be no inducement in exchange for patient referrals nor shall there be deception of a patient as to the identity of any medical or dental practitioners providing treatment or clinical services. Finally, no LIP shall delegate the responsibility for the diagnosis or care of hospitalized patients to another practitioner or professional discipline that is not qualified to undertake this responsibility. Any existing or potential conflict of interest involving LIPs and/or staff must be disclosed.

## **3.3 – Medical Staff Credentialing and Clinical Privileging Process**

**3.3.1 – General Process:** The Medical Staff, recognizing its responsibilities to all patients served, has established through its Department of Psychiatry and Medicine and Credentials Committee, a process of credentials evaluation and hospital-specific clinical privileging. This process exists to ensure that all applicants who are employed by or under contract with the Department of Psychiatry and Medicine, are competent qualified and have the knowledge and skills required to appropriately evaluate and treat patients within the scope of the privileges granted. All practitioners applying for Medical Staff Membership shall be credentialed and granted clinical privileges as a condition of appointment (employment) prior to the start of any clinical work. The Clinical Director shall hold the Credentials Committee responsible for making recommendations to him/her concerning initial Medical Staff appointments, reappointments, revisions of clinical privileges, and the granting of clinical privileges. The Credentials Committee will be responsible to make recommendations pertaining to approval of clinical privileges for physician assistants/students, nurse practitioners/students, and medical residents/fellows/medical students in conformity with these Bylaws. The Medical Staff Executive Committee will receive information related to the granting, modification or restriction decisions of clinical privileges and, where appropriate, further disseminate this information to the entire Medical Staff at the monthly Medical Staff meeting.

**3.3.1.1 – Medical Staff appointments** shall be made by the Clinical Director and confirmed by the CEO and SHC Executive Council, after a review of the recommendations of the Credentials and Medical Staff Executive Committees. All State of Maryland Personnel and Pensions articles and/or regulations will apply to all Medical Staff appointments and other related procedures as appropriate.

**3.3.1.2 – Medical Staff appointment and membership** shall confer on the appointee only those clinical privileges that are officially requested, reviewed and granted.

3.3.1.3 – Each application shall be signed by the applicant and indicate an acknowledgment of his/her responsibility to abide by the Bylaws, policies and procedures of the Medical Staff, the Department of Psychiatry and Medicine and SHC.

3.3.1.4 – The mechanism for Medical Staff appointment and the delineation of clinical privileges is fully described to each applicant at the time of initial application or reappointment.

3.3.1.5 – All approved and granted clinical privileges must be accompanied by an appointment letter.

**3.3.2 – Medical Staff Membership Application** - The verification of credentials will be done by SHC through the Medical Staff Credentials Committee. The following credentials and other required data are gathered as part of the application for Medical Staff appointment. Each item that follows is gathered to determine current professional competency and ensure that patients receive quality care. Medical staff membership and professional privileges are not dependent solely upon certification, fellowship or membership in a specialty body or society:

1. A completed, signed and dated application for employment or signed contractual agreement.
2. A completed, signed and dated application for clinical privileges and Medical Staff Membership. This application shall include a statement of applicant's compliance with the Medical Staff Bylaws, Hospital and Department of Psychiatry and Medicine rules, regulations and policies, and a consent form for the inspection of all pertinent records and documents. In addition, the applicant must agree to appear for an interview if one is requested.
3. A copy of the professional, e.g. medical, osteopathic, dental, optometrist, audiologist, physician assistant, nurse practitioner or podiatric school diploma (primary source verification required).
4. Educational Commission for Foreign Medical Graduates (ECFMG) Certificate /United State Medical Licensure Examination (USMLE), or equivalent, if applicable. (Primary source verification required)
5. A copy of certificate of internship and residency training (primary source verification required).
6. A copy of current Maryland professional license to practice medical, dental, or podiatric license, or license registration (primary source verification required) and relevant data concerning any history of denial, probation, limitation, suspension, or revocation of a professional license to practice a health care specialty in any state.
7. A copy of current Federal Drug Enforcement Agency and State of Maryland, Controlled and Dangerous Substances Registration Certificates, (if previously obtained), and any history of revocation, restriction, probation, suspension or other disciplinary action and the reasons.
8. A copy of board certification in any specialty or proof of certification from a specialty board, if applicable.
9. At least two current practice assessments from previous or current supervisors, Department Directors or physician peers in the same professional discipline who

have knowledge of applicant's professional activities at each hospital where applicant was granted clinical privileges; or the names and addresses of references to whom letters of inquiry can be sent. Letters of reference must address the clinical privileges requested.

10. Current curriculum vitae.
11. A statement regarding the applicant's medical history and current mental and physical status as they pertain to the applicant's ability to perform the duties required. Initial applicants may have their health status confirmed by the director of a training program, the chief of services, or the chief of staff at another hospital at which the applicant holds privileges, or by a currently licensed physician approved by the organized medical staff.
12. History of denial, reduction, suspension, or revocation, or any adverse action taken on the clinical privileges of the applicant at any hospital or health care facility and the reasons for such actions. These will be verified by the National Practitioner's Data Bank (NPDB).
13. History of termination of employment at any hospital or health care facility whether voluntary or forced as a result of an investigation into the applicant's professional activities.
14. History of any disciplinary action by any federal agency, professional organization or medical board of any state, and reasons for such actions.
15. History of any professional liability claims against applicant, past and current and status of the claim or claims.
16. History of professional liability coverage from initial coverage to present including any gaps in coverage and reasons for gaps. A copy of the current coverage or copy of a current certificate of insurance must be included.
17. Signed authorization to release information (relevant to applicant's qualification and competence) to the Credentials Committee and Hospital Administration of SHC from any physician or hospital or Health Care Facility with which the applicant was formerly associated.
18. Documentation of Continuing Medical Education credits which met/meets the requirements of Maryland law for the past and current year.
19. Documentation of Basic Life Support competence. As per Medical Staff Credentialing Policy
20. Citation of any additional relevant training, experience or evidence that the applicant is currently competent in a specialized area. Any special training or experience claim, which has been cited, or has a bearing or pertinence to clinical privileges being applied for must be documented and verified.
21. Each applicant pledges to provide continuous care for his/her patients and acknowledges any provision in the Bylaws for release and immunity from civil liability.
22. Individuals obtaining privileges to provide psychiatric treatment to adolescents must have the following credentials:
  - a. Completion of Child and Adolescent Psychiatry Residency Program (clinical experience can be substituted, if approved by the Credentials Committee and the Clinical Director).
  - b. Experience in treating seriously mentally ill adolescents.
  - c. Expertise in the following: Family Systems, Educational Assessments, Special Activities Needs, Pediatric Psychopharmacology and Behavioral Therapy of

Children and Adolescents.

23. All the above listed credentials and other required information shall be presented by the applicant for review by the Credentials Committee.
24. Relevant practitioner-specific data are compared to aggregate data, when available.
25. Performance Measurement Data including morbidity and mortality data, when available.
26. Information concerning professional performance, including clinical and technical skills and information from hospital performance improvement activities, when such data are available.
27. Upon initial application or renewal of privileges, when insufficient practitioner-specific data are available, peer recommendations are obtained and evaluated. Peer recommendations shall include the following information: medical/clinical knowledge, technical/clinical skills, clinical judgment, interpersonal skills, communication skills and professionalism.

### **3.3.3 – Specific Procedures for Membership Application Review and Approval -**

As soon as practical, but within 30 days after all the credentials and required information have been verified, the Credentials Committee shall meet to review and evaluate the applicant's credentials, qualifications and current competence. Completed medical staff/clinical privileging applications of persons seeking initial Medical Staff appointment should reach the Chairperson of the Credentials Committee within three months of application for employment and should be acted upon in no more than three months from that time. If a completed application is not received in a timely fashion, then the application for clinical privileges will be considered null and void.

3.3.3.1 – The evaluation of the committee and its decision shall be based solely on the applicant's education, training, experience, current competence and judgment and past performance in the case of reappraisal or reappointment. Medical staff membership and professional privileges are not dependent solely upon certification, fellowship or membership in a specialty body or society.

3.3.3.2 – The following shall not be used or considered in the evaluation of the applicant's credentials and qualifications, or in granting/denying requests for clinical privileges:

1. Age;
2. Race;
3. Gender;
4. Sexual Preference;
5. Nationality;
6. National Origin;
7. Disability;
8. Religion; or
9. Political Affiliations.

The same criteria shall be applied equally to all applicants. Each applicant acknowledges any provisions in Medical Staff Bylaws for release and immunity from

civil liability.

3.3.3.3 – The Credentialing and Privileging Process shall consist of the following components:

1. Evaluation to determine the applicant's qualifications for Membership in the Department of Psychiatry and Medicine and to the Medical Staff.
2. Delineation of clinical privileges to be granted based on professional education, training, experience and competence.
3. Periodic reappraisal, at least once every two years, of the previous performance of each Member of the Medical Staff to ensure that:
  - a. Competence is maintained;
  - b. Past performance is consistent with the clinical privileges granted;
  - c. All requirements for Medical Staff reappointment are met.
4. Documented participation in continuing professional education.

3.3.3.4 – The Credentialing and Privileging Process and its requirements or criteria shall apply to all LIPs, PAs/Nurse Practitioners, Medical Students, PA Students/Nurse Practitioner Students, Medical Residents, who admit, examine and treat patients in this hospital.

3.3.3.5 – All applicants for initial Membership or reappointment to the Medical Staff shall be informed in writing regarding approval or disapproval of their application within 30 days after the action has been taken.

3.3.3.6 – If the disposition taken is adverse (e.g. denial, reduction, etc.), current employees and Medical Staff Members will be informed in writing of the reasons for such action or actions, any right to appeal and a description of the appeals process (including a specified time to appeal). The specific process for this appeal is described in a later section (Section 3.3.5 – Fair Hearing and Appeal Procedures). Individuals seeking initial SHC and Medical Staff appointment will be provided with the reason(s) for denial and may request additional information by submitting a written request to SHC's Director of Human Resources.

3.3.3.7 – When the recommendation of the Credentials Committee is to defer a completed initial or reappointment application for further discussion or review, it must be followed at its next regular meeting with one of the three following recommendations:

1. Appointment with specified clinical privileges;
2. Extension of provisional privileges; or
3. Denial of Medical Staff privileges.

3.3.3.8 – Once the Credentials Committee has recommended denial, acceptance or modification of an applicant's request for Membership/clinical privileges, it shall submit the application and other supporting documents to the Medical Staff Executive Committee for review. The application for appointment along with the recommendations of the Credentials and Medical Staff Executive Committees are then sent to the Clinical

Director for action. The Clinical Director must confirm or deny the reviewed application and recommendations within one month of receiving it and then pass it on to the CEO and SHC Executive Council for confirmation or appeal (Section 3.3.3.9).

3.3.3.9 – Whenever the decision of the Clinical Director is contrary to the recommendations of the Credentials and/or Medical Staff Executive Committee, the Clinical Director shall review the matter with the President of the Medical Staff before submitting it through the CEO to the SHC Executive Council for review and decision. The SHC Executive Council shall consider all recommendations and may request an interview with the applicant before making a final decision. The SHC Executive Council's final decision shall be made within 90 days of receiving a request for review.

3.3.3.10 – In such disputed cases the SHC Executive Council's decision is final at the facility level. The SHC Executive Council shall send a written notice of its decision through the CEO to the Clinical Director with copies to the Medical Staff President, and by mail, to the applicant. Once the decision of the SHC Executive Council is received by the applicant, he/she may file a written appeal within 30 days to the BHA Facilities' Governing Body, Joint Conference Committee (as described in Article VII – Corrective Actions, Suspensions and Rights of Appeal, Section 7.6 – Joint Conference Committee). In such mediated cases the BHA Facilities' Governing Body Joint Conference Committee's decision is final at the appellate level.

3.3.3.11 – The BHA Facilities' Governing Body shall give final approval to all new appointments and reappointments subject to the provisions of these Bylaws, its Bylaws, the Maryland State Personnel and Pensions Article, and other applicable State laws and regulations, as evidenced either by confirmation by its representative in undisputed cases, or by its own decision, as described in Section 3.3.3.10, in disputed cases.

**3.3.4 – Granting of Clinical Privileges** - Delineated clinical privileges are granted in accordance with these Bylaws and those of the SHC Executive Council and BHA Facilities' Governing Body Bylaws. Privileges may not be granted for longer than two years at a time. Prior to granting clinical privileges the Credentials Committee will review the resources, equipment, types of personnel, necessary to support the requested privilege and determine them to be currently available, or available within a specified timeframe.

3.3.4.1 – Delineated clinical privileges are granted only when specified professional criteria, uniformly applied to all applicants, are met. These criteria, designed to assure that patients receive quality care, include evidence of current licensure, relevant training and experience, current competence, and acceptable health status. The applicant for privileges must report current professional liability action and the results of prior judgments or settlements involving him/her. Other criteria may also be drawn up by the Credentials Committee, by majority vote, subject to approval by the Clinical Director, and should Committees, or other mechanisms designed to be fair and ensure the delivery of quality care.

3.3.4.2 – The accuracy of the material presented with the application is verified by the hospital by contacting the primary source when possible and by other sources when not possible. The decision to grant or deny privileges is not made until such information is properly verified. In addition, information shall be solicited concerning successful or pending challenges to licensure or registration, the voluntary relinquishment of such licensure or registration, or the termination or reduction of Medical Staff Membership or privileges at any other hospital. Completed applications for appointment should ordinarily be acted on within three months.

3.3.4.3 – A separate record is maintained for each person who requests individual clinical privileges.

3.3.4.4 – The granting of privileges shall be related to the individual's documented experience in evaluating and treating patients in specific ways, the success of his/her treatment of patients, and information received from appropriate committees. If the decision is based primarily on the individual's experience (as is usually the case with new applicants), the record should reflect the specific experience and successful results on which the decision has been made.

3.3.4.5 – Admission privileges are granted only to physician Members of the Medical Staff, in accordance with state law and criteria for standards of medical care devised by the Medical Staff. All admitted patients have histories taken and comprehensive physical examinations done by properly privileged physicians. Each patient's general medical condition is the responsibility of a qualified physician Member of the Medical Staff. Individuals provide examination, treatment and perform invasive diagnostic procedures only within the scope of their delineated clinical privileges. Individuals engaged by the hospital to provide medical services pursuant to a contract shall apply for clinical privileges, which are then granted or denied under the same mechanisms as described above.

3.3.4.6 – **Temporary Privileges** – Under certain circumstances, temporary clinical privileges may be granted for a limited period of time. The two circumstances for which the granting of temporary privileges is acceptable are:

1. To fulfill an important patient care, treatment, and service need, and
2. When a new applicant with a complete application that raises no concerns is awaiting review and approval of the Medical Staff Executive Committee and the Governing Body.

Temporary privileges for the fulfillment of important patient care, treatment, and service needs are time limited and are not to exceed 120 days. In an emergency, any Medical Staff Member with clinical privileges is permitted to provide any type of patient care, treatment, and services necessary as a life-saving measure or to prevent serious harm, regardless of his or her Medical Staff status or clinical privileges, provided that the care, treatment, and services provided are within the scope of the individual's license. Temporary privileges will be granted to meet an important patient care need. When temporary privileges are granted to meet an important care need, current licensure and

current competence shall be verified.

New Applicants: Temporary privileges for new applicants may be granted while awaiting review and approval by the Medical Executive Committee upon verification of the following:

1. Current licensure.
2. Relevant training or experience.
3. Current competence.
4. Ability to perform the privileges requested.
5. Other criteria required by the Medical Staff Bylaws as described in section 3.3.2.
6. A query and evaluation of the National Practitioner Data Bank (NPDB) information.
7. A complete application.
8. No current or previously successful challenge to licensure or registration.
9. No subjection to involuntary termination of Medical Staff Membership at another organization.
10. No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges.

All temporary privileges are granted by the CEO or authorized designee. All temporary privileges are granted on the recommendation of the Medical Staff President or authorized designee. Temporary privileges for new applicants are granted for no more than 120 days.

**3.3.4.7 – Disaster Privileges** - Disaster privileges may be granted when the hospital's Emergency Management Plan has been activated and the hospital is unable to handle the immediate patient needs. During disaster(s) in which the Emergency Management Plan has been activated, the CEO or Medical Staff President or their designee(s) has the option to grant disaster privileges. The Medical Staff addresses the verification process as a high priority. The Credentials Committee of the Medical Staff begins the verification process of the credentials and privileges of individuals who receive disaster privileges as soon as the immediate situation is under control. This verification process is identical to the process established under the Medical Staff Bylaws or other documents for granting temporary privileges to meet an important patient care need. The CEO or the President of the Medical Staff or their designee(s) may grant disaster privileges upon presentation of a valid picture ID issued by a state or federal agency and any one of the following:

1. A current picture identification card from a health care organization that clearly identifies professional designation.
2. A current license to practice.
3. Primary source verification of licensure.
4. Identification indicating that the individual is a Member of a disaster medical assistance team.
5. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity).



6. Presentation by current hospital or Medical Staff Member(s) with personal knowledge regarding practitioner's identity.

The President of Medical Staff or Clinical Director/designee will assign a medical staff mentor to oversee the professional performance of volunteer practitioners who receive disaster privileges. Springfield Hospital Center will provide a volunteer practitioner ID badge.

Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization.

The President of the Medical Staff or Clinical Director/designee will make a decision based on information obtained regarding the professional practice of the volunteer within 72 hours related to the continuation of the disaster privileges initially granted.

**3.3.4.8 – Revision of Privileges** - In the interim between appointment and reappointment, or between reappointments, the scope of clinical privileges may, upon request by the staff Member, be modified for good cause. Modification examples: a) add or delete supplemental privileges to an existing core; b) add or delete itemized privileges to an existing itemized list. Any staff Member who is a subject of a pending corrective action or who has been granted temporary privileges and whose application has not yet been the subject of final action by the Governing Body shall not be eligible for modifications of privileges. A staff Member desiring modification of privileges shall make the request in writing to the privileging authority via Credentials Committee or Clinical Director. The staff Member shall provide supporting documentation in the request. The denial of requested additional or increased privileges shall not entitle the staff Member to request a hearing but the affected staff Member shall be entitled to request the Governing Body or Clinical Director to reconsider such action and submit additional information in support of the request. When modifying clinical privileges, the expiration date of the staff Member's current appointment should not be modified.

**3.3.5 – Fair Hearing and Appeal Procedures** - An applicant for who wishes to appeal the Clinical Director's disapproval of a request for Medical Staff reappointment or renewal of clinical privileges may ask the President of the Medical Staff to convene a special Hearing Panel. This request must be made in writing within 14 days of receipt of notification of the adverse decision. The President of the Medical Staff must then ask the Medical Staff Executive Committee to appoint within 14 days, a Special Hearing Panel, which is to convene the hearing no sooner than 30 days from the time of its formation and no later than 45 days from the time of its formation. It is to consist of at least three Medical Staff Members; if possible, none should have served on the Credentials Committee and at least one should specialize in the same area as the applicant. The Medical Staff Executive Committee, by majority vote of a quorum of its Members, shall select one of the Members of the Special Hearing Panel to serve as its Chairperson. The applicant must attend the hearing and has the rights accorded participants in any judicial proceeding, including the right to call witnesses, to cross-examine witnesses, and to retain the services of an attorney. The Chairperson of the

Credentials Committee shall present the other side of the case. A written record of the hearing is to be made. The Special Hearing Panel is to make a decision by majority vote of these Members present (50% constituting a quorum) and the Chairperson shall submit a report of its conclusions to the Medical Staff Executive Committee within two working days of the vote. The Medical Staff Executive Committee shall then submit within three working days its own conclusions along with the conclusions of the Special Hearing Panel's to the Clinical Director for decision and action. A copy of these conclusions and the Clinical Director's decisions and actions must be sent to the applicant initiating the appeal. The applicant may then appeal the actions of the Medical Staff Executive Committee and the Clinical Director to the SHC Governing Body as described in 3.3.3.9 and 3.3.3.10.

**3.4 – Terms of Appointment** - The terms of appointment to the Medical Staff shall be two years or less. The two years shall include the provisional period.

3.4.1 – All initial appointment of LIPs and PA/NPs by SHC shall be provisional for the first six months. Provisional status can be extended for one more term of six months, if needed. The consultants' provisional status will be for a term of two years, with reappointment from that period on. All applicants granted provisional appointments shall be so informed of the provisional status at the time of their initial appointment.

3.4.2 - Contractual physicians or staff who are employed by an agency which has a contract with SHC to provide medical/dental services shall have their Medical Staff membership and/or clinical privileges granted contingent on their continued employment with the contracting agency, but for no more than two years at a time. Termination of their employment with such agency shall automatically terminate their Medical Staff membership and clinical privileges. They shall be so informed of this at the time of their initial appointment.

3.4.3 – Individuals currently in administrative positions or those seeking new membership in administrative positions are to be appointed or reappointed through the same procedure as other Members and their requests for clinical privileges shall be granted or denied through the same procedures.

3.4.4 - Temporary consulting privileges may be granted to a physician who is not a Member of the Medical Staff where it is demonstrated that such action will produce a beneficial effect upon the quality of the medical care as a result of the participation of such physician in the management of a specific patient. In any such instances, the attending physician at SHC will have the assigned responsibility for the quality of patient care and for the medical record. Such temporary consulting privileges may only be granted by the CEO, after consultation with the Clinical Director or his/her designee.

3.4.5 - Special requirements of supervision may be imposed by the Credentials Committee on any practitioner granted any of the requested provisional privileges. These privileges shall be immediately terminated by the Clinical Director upon notice of any failure by the physician to comply with such special conditions.

### **3.5 – Reports to State (Maryland) Physicians Board**

Any adverse action taken on a clinician's privileges of a Medical Staff Member may be reported to the State (Maryland) Board of Physicians by the Clinical Director or his/her designee within 10 days of the time of this action. An adverse action shall mean: any limitation, reduction, suspension, revocation, resignation, termination, denial (for initial applications or appointments only) if any such changes might be grounds for disciplinary action under Health Occupations §14-404, Annotated Code Maryland.

### **3.6 – Ongoing Professional Practice Evaluation**

Any Member of the Medical Staff who has been granted clinical privileges shall be subject to an ongoing evaluation of his/her performance through the Medical Staff's monitoring and evaluation mechanisms (Medical Staff committees' reports and clinical competency evaluations) the Hospital's Performance Improvement and Risk Management Programs, clinical supervision or any other mechanisms that may provide information about one's performance. Any identified adverse information pertinent to the Members' practice shall be reported in writing to the President of the Medical Staff, forwarded to the Credentials Committee for review and recommended action to the Clinical Director. The practitioner must be informed of any adverse action, and must be given a copy of any communication to the State (Maryland) Board of Physicians including all documentation supporting the adverse action. The practitioner must have the opportunity to include, in any appropriate committee's files, an explanatory document of any negative comment or documentation presented in his/her case.

### **3.7 – Reappointment Process**

3.7.1 - The Medical Staff reappointment process shall include a review and evaluation of the following:

3.7.1.1 – Updated information listed in the requirements for initial credentialing and the granting of privileges; including:

1. Status of licensure,
2. Challenges to licensure or registration,
3. Relinquishment of any licensure or registration, or
4. Termination of Medical Staff privileges or reduction of privileges at another hospital.

3.7.1.2 – Other reasonable indicators of continuing qualifications:

1. Review of current clinical skills, as indicated by input from SHC's Performance Improvement/Physicians' Quality Improvement Programs, Medical Staff Committees' Reports, Clinical Competency Evaluations and a review of the individual's current professional, physical, and mental competence.
2. Adherence to Medical Staff Bylaws.
3. Compliance with continuing medical education requirements.

4. Final malpractice judgments or settlements involving the individual.
5. Current mental and physical health as they relate to the individual's ability to perform some or all of his/her clinical privileges.
6. Attitudes, cooperation, and ability to work with other hospital staff.

The mechanisms for reappointment and the re-granting of clinical privileges are described to each individual who is seeking these.

3.7.2 – Assessments of clinical competency from two peers and the individual's supervisor are part of the basis for developing recommendations for reappointment and for the renewal of privileges, as are quality improvement findings.

3.7.3 – When due for reappointment, staff will be so notified by the Credentials Committee at least 30 days in advance. All applicants for reappointment shall file an application for renewal and shall have the burden of supplying all required documents and required information listed previously (Section 3.3.2 – Specific Procedures for Medical Staff Membership Application) with their applications. Documents already on file need not be duplicated.

3.7.4 - The evaluation process shall be the same for reappointment and renewal of privileges as previously described for initial appointment. (Sections 3.3.2 (Specific Procedures for Medical Staff Membership Application) - 3.3.4 (Terms of Appointment)). Reappointment and renewal of clinical privileges shall be for two years at a time.

3.7.5 - All matters considered in the reappointment process shall be part of the permanent records of the Credentials Committee.

3.7.6 - Applicants should have an opportunity to appeal adverse decisions according to the Medical Staff Bylaws. Cases of adverse recommendation shall be processed in accordance with Sections 3.3.3.8 - 3.3.3.10 (Specific Procedures for Medical Staff Membership Application) and 3.3.5 (Fair Hearing and Appeal Procedures). In disputed cases, the Medical Staff shall render a decision based on a special hearing as previously described in Section 3.3.5 (Fair Hearing and Appeal Procedures) and the SHC Executive Council will review this decision within three months of being notified of the dispute. In undisputed cases, confirmation of reappointment and renewal of clinical privileges is made by SHC Executive Council's in a timely fashion.

3.7.7 - In those instances where actual verification of documents is impossible or extremely difficult, all attempts to obtain the needed verification must be documented in the credentials files, including any affidavits from the applicant practitioner and/or other authoritative sources.

3.7.8 - When considering reappointment or any changes in the renewal of clinical privileges, the hospital should consider the individual's previous activities at the hospital as demonstrated in statistical data, peer review results and other sources.

**3.8 - Focused Professional Practice Evaluation (FPPE):** Focused Professional Practice Evaluation is a systematic process to evaluate and confirm the privilege-specific competence of a practitioner who either: does not otherwise have documented evidence of competency to perform the requested privilege at SHC and/or when there are concerns regarding the provision of safe and high quality care by a current medical practitioner. This process will be applied to all requests for new privileges. Any concerns regarding the practice of an individual will be brought to the Medical Executive Committee. When the Medical Executive Committee determines that an FPPE shall be done, the physician will be informed of the reason for the FPPE and given details about how the review process will be conducted. Relevant information resulting from the focused evaluation process is integrated into performance improvement activities, consistent with Springfield Hospital Center policies and procedures that are intended to preserve confidentiality and privilege of information.

**3.8.1 -** The FPPE process includes an assessment for proficiency in the following six areas of general competency:

1. Patient care
2. Medical and clinical knowledge
3. Practice-based learning and improvement
4. Interpersonal and communication skills
5. Professionalism
6. Systems-based practice

**3.8.2 –** Information for Focused Professional Practice Evaluation may be derived from the following:

1. Discussion with other individuals involved in the care of each patient (e.g. consulting physicians, physician assistants, nursing, administrative personnel or unit team members)
2. Chart Review
3. Monitoring clinical practice patterns
4. Proctoring/Direct Observation
5. Simulation
6. Peer Review

**3.8.3 –** Responsibilities:

1. The Associate Clinical Director, Director of Medical Service or their designee, shall be responsible for overseeing the evaluation process for all practitioners.
2. The Associate Clinical Director or Director of Medical Services shall be responsible for monitoring compliance with this process.

The Associate Clinical Director or the Director of Medical Services will forward status reports on the progress of practitioners undergoing focused evaluation as well as any issues or problems involving the implementation of the process to the credentials

committee.

### 3.8.4 - Performance of FPPE

The type of focused professional performance evaluation will be determined by either the immediate supervisor, Clinical/Associate Clinical Director or the Director of Medical Services based on the individual practitioner's circumstance(s) using the following guidelines:

#### 3.8.4.1 - New applicant

1. FPPE will be completed by the Associate Clinical Director or the Director of Medical Services or their designee within six months.
2. A review of indicators or aggregate data will be monitored as part of the FPPE.

#### 3.8.4.2 - New privilege for Current Practitioner

If a new requested privilege is significantly different from one's current practice, then training in the new privilege or proctoring of cases should be arranged, documented, and confirmed. This process and the number of cases necessary should be determined by the Associate Clinical Director or the Director of Medical Services and the credentials committee.

#### 3.8.4.3 - Concerns Regarding Provisions of Safe and High Quality Care.

1. FPPE may be required as a result of Focused Review as described in Article 5.2.1.5.
2. The Associate Clinical Director or Director of Medical Services will establish a plan on an individual basis to be approved by the medical executive committee.

### 3.8.5 – Duration of FPPE

FPPE shall start when the applicant begins clinical activity or performance of a newly requested privilege. The Associate Clinical Director, The Director of Medical Services or their designee will determine the number-and scope of activities to be reviewed.

FPPE for new applicants should be completed by six (6) months. All proctoring activity, summaries, and reports need to be completed prior to the end of the six (6) month initial appointment cycle

### 3.8.6 – Supervision of FPPE

Assignment of focused professional practice evaluations will be the responsibility of the Associate Clinical Director or the Director of Medical Services. The Associate Clinical Director or the Director of Medical Services may appoint active staff members to complete the appropriate tasks which may include proctoring/observing.

### 3.8.7 – Proctor Qualifications

The following guidelines shall be used for proctoring:

1. Proctors must be Member(s) of the Medical Staff of Springfield Hospital Center.
2. The proctor shall be a member of the same Service (or Division) as the Physician being proctored.

### 3.8.8 – Responsibilities of Proctors

1. Proctor(s) shall directly observe the performance of procedures, concurrently observe medical management or retrospectively review the completed medical record and will complete appropriate reports.
2. Ensure confidentiality of proctor(s) results and reports. Submit completed reports to the Associate Clinical Director, Director of Medical Services or their designee.
3. Submit a summary report at conclusion of proctoring period.
4. If at any time during the proctoring period, proctor(s) have concerns about the practitioner's competency to perform specific clinical privileges the proctor(s) shall promptly notify the Associate Clinical Director or Director of Medical Services or their designee.

### 3.8.9 - Competency Assessment every six months for each privileged Member

The Associate Clinical Director or Director of Medical Services or their designee will complete a Competency Assessment Form for each Member, every six (6) months, at the time of the Performance Evaluation Program (PEP). The Associate Clinical Director or The Director of Medical Services or their designee shall use the FPPE process to determine the competency of each Member.

The Clinical Director will complete the competency assessment form for the Associate Clinical Director every six (6) months at the time of the Performance Evaluation Program (PEP).

The Clinical Director of BHA/ADAA will complete a competency assessment form for the Clinical Director every six (6) months at the time of the Performance Evaluation Program (PEP).

## **ARTICLE IV – CATEGORIES OF APPOINTMENT**

### **4.1 – Membership**

Voting and non-voting Staff are assigned to one of the following categories:

1. Provisional
2. Active
3. Associate Physician

4. Active Consultant (Non-Courtesy)
5. Telemedicine
6. Courtesy Consultant
7. Adjunct Staff
8. Ancillary Staff

The privileges of all categories of Medical Staff are described in each individual's clinical privileges delineation form.

**4.1.1 – Provisional** – This is the initial medical staff category for those LIP and PA/NPs who have presented a written application for employment and Medical Staff appointment, who have agreed to abide by the Medical Staff Bylaws and SHC policies, whose qualifications have been evaluated and who have been recommended for Appointment by the Credentials Committee. A Member must meet the qualifications required by the appropriate State (Maryland) Licensing Board and the State Personnel and Pensions Article. Practitioners are responsible for providing a uniform standard of quality patient care and treatment services within the scope of their privileges.

**4.1.1.1** - All initial Medical Staff appointments shall be provisional until the applicant completes his or her provisional period. All Consultants initial provisional status will be for a term of two years, with reappointment from that period on. Recommendation for active Appointment will then be made to the Clinical Director by the Chairman of the Credentials Committee, with notification to the President of the Medical Staff.

**4.1.1.2** – Except for consultants whose provisional status is for two years, appointment to provisional Appointment shall be reviewed at least every six months and appointees may not ordinarily remain on provisional status for more than one year. Justification for extending provisional status for more than six months must be made in the individual credentials file. If an appointee fails to advance from provisional to active Appointment within one year, a written recommendation for Medical Staff Appointment termination citing the specific reasons shall be made by the Chairperson of the Credentials Committee to the President of the Medical Staff and Clinical Director. In this instance, the provisional appointee shall have the rights of appeal accorded by these Bylaws to any active Member who has failed to be recommended for reappointment.

**4.1.1.3** - Provisional staff Members shall be given a clinical assignment such that their performance will be directly observed by the Associate Clinical Director/Director of Medical Services or designee.

**4.1.1.4** – All Provisional staff Members are ineligible to vote or hold office. They may, however, serve on clinical or administrative committees of the Medical Staff or the Department of Psychiatry and Medicine.

**4.1.2 - Active - M.D.'s and D.O.'s** who are licensed in the State of Maryland, who have presented a written application for Medical Staff Appointment, who have agreed to abide by the Medical Staff Bylaws and SHC policies, whose qualifications have been



evaluated by the Credentials Committee and who have successfully completed a provisional period. The Member must also meet any new or ongoing qualifications or requirements of the appropriate State (Maryland) Licensing Board and the State Personnel and Pensions Article. Appointments to Active Staff are made by the Clinical Director, upon the recommendation of the Chairman of the Credentials Committee after a complete application is received, reviewed and approved by the Credentials Committee, Medical Staff Executive Committee, and SHC Executive Council. Any Member, who has special training and/or is qualified in a specialized field, may be given additional privileges upon the recommendations of the Credentials Committee and the Clinical Director. Each active Member shall assume responsibilities of abiding by Medical Staff Bylaws, Department of Psychiatry and Medicine and SHC policies and shall take an active role in the functions of the Department of Psychiatry and Medicine and the Medical Staff. Only active Members shall be eligible to vote and hold office.

**4.1.3 - Associate Physician** - Those physicians who are not active Members of the Medical Staff but who are licensed to practice medicine in the State of Maryland, whose qualifications have been evaluated by the Credentials Committee and who meet any new or ongoing qualifications or requirements of the State (Maryland) Board of Medical Examiners and the State Personnel and Pensions Article. Privileges shall be granted in the same manner and extent as for active Members, except that the associate Member shall remain under the supervision of designated active Member of the Medical Staff, usually the Director of Medical Services and Associate Clinical Director. Appointments to the Associate Physician Membership are made by the Clinical Director upon the recommendation of the Chairperson of the Credentials Committee after a complete application is received, reviewed and approved by the Credentials Committee, Medical Staff Executive Committee, and SHC Executive Council. This category includes Physicians that serve as Officer of the Day, POD or SPODs who are not Members of the Active Medical Staff. Associate Members are ineligible to vote or to hold office.

**4.1.4 – Active Consultant (Non-courtesy)** - All medical practitioners of recognized professional ability who consult at SHC on an ongoing basis about patient diagnosis and treatment. Appointments to the Consultant Staff are made by the Clinical Director upon the recommendation of the Chairperson of the Credentials Committee after a complete application is received, reviewed and approved by the Credentials Committee, Medical Staff Executive Committee, and SHC Executive Council. Practitioners appointed to the consulting-staff shall have appropriate qualifications to act in a consultant capacity and shall be granted privileges that are consistent with their training, experience and capability and that delineate the intended scope of practice. Active Consultant staff are ineligible to vote or hold office and are not Members of the medical staff.

**4.1.4.5 – Telemedicine** -Telemedicine is the use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or health care provider and for the purpose of improving patient care, treatment, and services. Telemedicine may be used in special circumstances at SHC to meet patient care, treatment and services. The Medical Staff will recommend which

clinical services are appropriately delivered by LIPs through a telemedicine link. Clinical services offered through telemedicine will be consistent with commonly accepted quality standards and meet relevant Joint Commission standards.

Requirements: Telemedicine services focus solely on the LIPs that have total or shared responsibility for patient care, treatment, and services through a telemedicine link. All LIPs who are responsible for the care, treatment, and services of the patient via the telemedicine link will be subject to the credentialing and privileging process of the SHC Medical Staff Bylaws and credentialing standards. A current Maryland license to practice medicine is required. If the LIP is part of a Joint Commission accredited facility, SHC will do one of the following:

1. Specify in the contract that the contracting entity will ensure that all services provided by contracted individuals who are LIPs will be within the scope of his/her privileges, or
2. Verify that all contracted individuals who are LIPs and who will be providing patient care, treatment, and services have appropriate privileges by obtaining a copy of the list of privileges from the other facility.

Telemedicine equipment and maintenance will be the responsibility of the distant site where the practitioner providing the medical service is located. The originating site where the patient is located at the time the service is provided (SHC) retains the responsibility for overseeing the safety and quality of the services provided to its patients.

Radiology services at SHC are approved for telemedicine.

**4.1.6 – Courtesy Consultant** - All medical and dental-practitioners including LIPs of recognized professional ability who consult at SHC on an infrequent basis, four times a year or less, about patient diagnosis and treatment upon request from the Medical Staff will be Courtesy Consultant Staff. Appointments to the Courtesy Consultant Staff are made by the Clinical Director upon the recommendation of the Chairperson of the Credentials Committee after a complete application is reviewed and approved by the Credentials Committee, Medical Staff Executive Committee and SHC Executive Council. Courtesy Consultant Staff are ineligible to vote and hold office.

**4.1.7 - Adjunct Staff**- The adjunct staff shall consist of those audiologist, dentist, optometrist and podiatrist of recognized professional ability who consult at SHC on an ongoing basis about patient diagnosis and treatment. Appointments to the adjunct staff are made by the Clinical Director upon the recommendation of the Chairperson of the Credentials Committee after a completed application is received, reviewed and approved by the Credentials Committee, Medical Staff Executive Committee and SHC Executive Council. Clinical privileges shall be consistent with the appointed audiologist, dentist, optometrist or podiatrist training, experience and capability and should delineate the intended scope of practice. The following qualifications must be met for application:

1. Graduation from an accredited professional training program in the specified field of

Podiatry, Optometry, Audiology, or Dentistry.

2. Licensed in the State of Maryland in their specialized field. Adjunct Staff are ineligible to vote or hold office.

**4.1.8 - Ancillary Staff** - Practitioners who require clinical supervision and students enrolled in an accredited training program. Ancillary staff are ineligible to vote or hold office.

**4.1.8.1- Resident/Fellow Staff** - The Resident/Fellow staff shall consist of those physicians who are graduates of a recognized or approved medical school, who are licensed in the State of Maryland, who are members in good standing in a psychiatric residency or post-residency fellowship training, who rotate through their training at SHC, and who treat patients in the hospital under the supervision of a Member of the Medical Staff. Medical Staff Members who choose not to supervise are not subject to denial or limitation of privileges for this reason alone. Residents/Fellows may write patient care orders and document care in the medical record since they shall receive regular supervision from Medical Staff Members in ways agreed upon by the training program, the Clinical Director, and those Members of the Medical Staff with a faculty appointment. Appointments to the Resident/Fellow Staff are made by the Clinical Director upon the recommendation of the Chairperson of the Credentials Committee after a complete application is received, reviewed and approved by the Credentials Committee, Medical Staff Executive Committee, and SHC Executive Council. (Appendix A – Policy on “Graduate Medical Education Programs”)

**4.1.8.2 – Medical or Physician Assistant Student Staff** - The Medical or Physician Assistant Student staff consists of Medical or Physician Assistant Students in active training and in good standing in an accredited Medical School or Physician Assistant Education Program, which has an Educational Affiliation Agreement with the SHC. Appointments to the Medical or Physician Assistant Student staff are made by the Clinical Director upon the recommendation of the Credentials Committee after proper review of the student’s application and documents submitted, and approval of the Credentials Committee, Medical Staff Executive Committee and the SHC Executive Committee. The Medical or Physician Assistant Students will evaluate and treat patients in the hospital under direct supervision of a Member of the Medical Staff. Members of the Medical Staff who choose not to supervise are not subject to denial or limitation of privileges for this reason alone. Medical or Physician Assistant Students may not write patient’s medication orders but can document care in the medical record and write non-medication orders under supervision of the Medical Staff Member who countersigns the documented care entries and the non-medication orders.

**4.1.8.3 – Physician Assistant and Nurse Practitioner Staff** - Physician Assistants are clinicians of the medical staff who are certified to perform delegated medical acts under the supervision of a supervising Physician as described in Health Occupations Article 15 annotated code of Maryland. Nurse Practitioners are clinicians of the Medical staff who are certified registered nurses who by reason of certification under COMAR 10.27.07 may practice in Maryland as a nurse practitioner under the terms of those regulations. They have a current Maryland license to practice for, provide care to

patients in the Hospital subject to Health Occupations Article Title 15 as promulgated in the Annotated Code of Maryland and COMAR Regulations 10.32.03 and 10.27.07 respectively and any amendments thereto. Physician assistants and nurse practitioners shall at all times conform to the requirements of the Medical Staff regulation and all policies for physician assistants and/or nurse practitioners, including any amendments thereto. Recommendations for privileges shall be made by the Credentials Committee and submitted to the Medical Staff Executive Committee and SHC Executive Council for subsequent review and approval. Privileges shall only be authorized pursuant to the requirements and limitations as outlined in these Bylaws and the Medical Services Department's Procedure for Supervising Physician Assistant. The Physician Assistant orders for patient care, progress notes and history and physicals do not require co-signature by a Primary or alternative supervising physician. Nurse practitioners are permitted to write orders on hospital approved Physician's Order Sheets and their progress notes do not require co-signature by a primary or supervising physician. Medical/Physician Assistant students, physician assistants, and nurse practitioners are not Medical Staff Members and are ineligible to vote or hold office, but are subject to the credentialing privileges process, as described in section 3.3 (Medical Staff Credentialing and Clinical Privileging Process)

#### **4.1.8.4 - Requirements for Privileges:**

1. All privileges of the physician assistant and/or nurse practitioner shall be under the direct supervision and responsibility of a primary supervising physician.
2. In the absence of the primary supervising physician the direct supervision and responsibility will be delegated by the primary supervising physician to an alternate supervising physician.
3. The supervising physician accepts responsibility for the care provided to patients and provides continuous availability and supervision of all actions of the physician assistant and or nurse practitioner.
4. Have an approved delegation agreement for physician assistant/nurse practitioner with scope of practice.
5. The facility to have a description of written process on the delegation agreement by which the physician assistant/nurse practitioners practice is reviewed appropriate to the practice setting and consistent with current standards of acceptable medical practice.
6. The physician assistant and/or nurse practitioner must abide by all policies and regulations of the Medical Staff and hospital.
7. The physician assistant, nurse practitioner, primary supervising physician and alternate supervising physician(s) must comply with all requirements of the Board (Maryland) of Physicians and COMAR governing the practice of physician assistants, nurse practitioners and physicians.

#### **4.1.8.5 - Job Description for Physician Assistants. Specific Duties Include:**

1. Perform new admission/annual/transfer history and physical examination.
2. Facilitates the development of medical diagnosis and appropriate patient treatment plans as authorized by the supervising physician.

3. Screen all assigned patients to determine need for medical management and treat any identified problems under the supervision of a physician.
4. Implements patient treatment plans by administration and prescribing medications, counseling patients, making referrals to other medical specialists and performing needed follow-up consultation or treatment.
5. Initiate appropriate evaluation and emergency management in cases of cardiac arrest/respiratory distress/burns, all trauma, etc.
6. Perform clinical procedures (venipuncture, IM, ECG, minor laceration, suturing, dressing and bandages, starting IV fluids, casting and splinting, control of external hemorrhage and bandages, administering non-narcotic medications and medical devices).
7. Manage pain with consultation of the supervising physician's.
8. Evaluate patients in regards to preventive health and disease management and immunizations, etc.
9. Educate patient's family too in regards to patient's medical management by being an active member of the treatment team.
10. Manage patients according to age specific needs, e.g. adolescents, adults, geriatrics, and patients with special needs, i.e. deaf (who will be managed with the assistance of interpreters).
11. Perform other related duties.

4.1.8.6. - Credentialing requirements are described in Article III – Membership Requirements and Article IV – Categories of Membership and Appointments. Privileges Requested as per hospital and credentialing policy.

## **ARTICLE V – OFFICERS AND COMMITTEES**

### **5.1 – Officers**

The officers of the Medical Staff shall be the President, Vice-President, and Treasurer. A new President, Vice-President and Treasurer shall be elected in June of each year at the last regular Medical Staff meeting prior to the end of the fiscal year (annual meeting). These individuals shall hold office for the next 12 months.

**5.1.1 - Nominating Committee** - The Committee is chosen by the Medical Staff Executive Committee before April 1<sup>st</sup> each year and consists of three (3) Members (two (2) psychiatrists and one (1) physician from Medical Services). The President of the Medical Staff shall name the chairperson and its functions shall be:

1. To nominate from among the active Members with at least one year of Membership of the Medical Staff, the President, Vice-President, Treasurer and four (4) candidates for positions on the Medical Staff Executive Committee and to procure the acceptance of each nominee so chosen.
2. To submit its slate of candidates to the full Membership of the Medical Staff at the monthly meeting of the staff in April. Additional nominations may be made by the Members at that time or in the May meeting.

If no valid additional nominations are made by the Medical Staff at its meetings in April or May and if the Nominating Committee's slate consists of only one nominee for each position, then the nominations shall be declared complete and no balloting will be required. If there are two (2) or more nominations for any position, then a ballot listing positions with multiple nominees shall be prepared and submitted to each Member in good standing upon his/her written registration as present at the meeting in June, and election by ballot will be required. Proxy/Absentee votes are permissible. Nominations cannot be made in any manner other than as provided above.

**5.1.2 - The President** - The President shall not serve for more than two successive one-year terms. The immediate Past President shall be available to the President for up to one year to provide advice and counsel and ensure continuity of service. The President or his/her designee shall call and preside at all regular and special meetings of the Medical Staff and Medical Executive Committees and shall be responsible for the agenda. The President or his/her designee shall also be responsible for approving and signing the minutes of the Medical Staff and Medical Executive Committees. The President shall be an ex-officio Member of all Medical Staff committees, except the Medical Staff Executive Committee, which he/she shall chair. The President shall represent the views, policies, needs and grievances of the Medical Staff to the Clinical Director, the CEO, and the SHC Executive Council. The President shall assist in enforcing the Medical Staff Bylaws and Department of Psychiatry and Medicine policies in conjunction with the Director of Medical Services, Associate Clinical Director and the Clinical Director. The President will interact with the Medical Staff, CEO, Clinical Director, and SHC Executive Council in all matters of mutual concern within the hospital. The President may form special (Ad Hoc) committees to help carry out necessary duties of the Medical Staff subject to the approval of the Medical Staff Executive Committee (Article V – Section 5.2.10 Special (Ad Hoc) Committees). The President may call and preside at a special meeting of the Medical Staff Executive Committee, which he/she chairs. The President can raise any significant Medical Staff issue or make any recommendation on behalf of the Medical Staff to the one or more Members of the SHC Executive Council. The President and Medical Staff Executive Committee are responsible for investigating and making recommendations concerning any allegations made towards Members of the Medical Staff. The President's recommendations are sent to the Clinical Director, who would be responsible for taking appropriate action, if warranted. In the event of vacancy in the President's position, the vice president shall succeed to the office of the President until the completion of that term.

**5.1.3 - The Vice-President** - The Vice-President, in the absence of the President, shall assume all duties and acquire the necessary authority. In the event that the office of the President is vacated, the Vice-President shall succeed to the office of President. In event of vacancy in the Vice-President position, a new Member should be elected from the Medical Staff to fulfill this position until the completion of that term. The Vice President shall have other responsibilities as delegated by the President.

**5.1.4 - The Treasurer** - The Treasurer shall be responsible for collecting and accounting for all monies managed by the Medical Staff and performing all other duties as ordinarily pertain to this office. The office is filled by election from the active Medical Staff. An unexpected vacancy is filled by an election at the next monthly Medical Staff meeting and the newly elected individual shall serve until the completion of that term. The Treasurer shall present a Medical Staff account summary in June the end of each fiscal year.

**5.1.5 - Removal of Elected Medical Staff Officers/Elected Medical Executive Committee Members** - Any elected Medical Staff officer, including the President, may be removed from office if he/she appears to be unable to discharge the functions of the office because of mental, physical, or any other impairment. Upon notification, the Medical Staff Executive Committee shall meet promptly under the direction of the President. If the President is being considered for removal from office, the Vice-President shall assume all duties of the President. The Medical Staff Executive Committee shall, after careful investigation and consultation, determine the appropriateness of the removal of any elected officer from office. Having decided that removal is appropriate, the Medical Executive Committee shall:

1. Consult with the Clinical Director.
2. Officially notify the Clinical Director of the proposed removal.
3. Officially notify the Medical Staff of the proposed removal of the elected officer.

A special meeting of the Medical Staff shall be called by the President/Acting President at the earliest possible time. The Medical Staff shall review the decision made and confirm or deny the decision by a simple majority vote of those present. Interim positions shall be filled at the discretion of the President, after consultation with the Medical Staff, regarding any officer position vacancy.

## **5.2 – Committees**

Committees of the Medical Staff shall be standing and special. All committees, chairpersons, and Members, except the Medical Staff Executive Committee, shall be appointed by the Clinical Director in conjunction with the President of the Medical Staff. The CEO shall be a non-voting Member ex-officio of all committees. For the appointment of committee Members from other clinical and non-clinical disciplines, the Clinical Director and the President of the Medical Staff shall request the discipline/department director to recommend an appropriate appointee. The written reports of the committees must be forwarded through the Medical Staff structure as specified below, and to the CEO and Medical Staff Executive Committee.

**5.2.1 – Medical Staff Executive Committee** – The Medical Staff Executive Committee shall consist of the following nine (9) voting Members: the President, the Vice-President, the Treasurer, the Director of Medical Services, the Associate Clinical Director, and four (4) Members to be elected from the active Medical Staff, at least one Member each from Medical Services and Psychiatric Services, for a term of one year. All Members of the active Medical Staff are eligible to serve on it. The President shall

serve as the Chairperson of this Committee. The CEO of the hospital or his/her designee and the Clinical Director or his/her designee shall attend all meetings on ex-officio basis as non-voting Members. A copy of the minutes of each meeting shall be sent to the SHC Executive Council, CEO, Clinical Director and all Medical Staff Members.

The organized medical staff delegates authority in accordance with law and regulation to the Medical Staff Executive committee to carry out the medical staff responsibilities. The Medical Staff Executive Committee carries out its work within the context of the organization functions of governance, leadership and performance improvement. The Medical Staff Executive Committee has the primary authority for activities related to self-governance of the Medical Staff and for performance improvement of the professional services provided by the licensed independent practitioners and other practitioners privileged through the medical staff process.

The structure and function of the Medical Staff Executive Committee conforms to the Medical Staff Bylaws and shall be:

1. To act for the Membership of the Medical Staff as a whole between medical staff meetings, under such limitations as may be imposed by the Medical Staff.
2. To review and act on all reports from the Medical Staff Committees, Departments, as well as other significant hospital committees and other assigned activity groups; such as Safety, Performance Improvement, departmental meetings, etc.
3. To assure the fulfillment of Medical Staff accountability to the Clinical Director and SHC Executive Council for the overall quality of medical care and treatment rendered to patients. Accordingly, it will make recommendations pertaining to the structure of the Medical Staff, the procedures used to review credentials and delineate individual clinical privileges, the inclusion of applicants for Medical Staff Membership, the process for delineating clinical privileges for eligible individuals, the organization of Quality Improvement activities of the Medical Staff (including the mechanism for conducting, evaluating, and revising such activities), the process for terminating Membership in the Medical Staff, and the mechanism for fair hearing procedures.
4. Professional Standards Review – To establish and maintain standards of professional clinical performance, professional ethical conduct, supervision and continuing education for Members of the Medical Staff.
5. Focused Review – An evaluation of performance triggered by a single incident affecting the provision of safe, high quality patient care or an overall trend which indicates a problem in one or more areas of performance. The primary goal of the focused review is to improve the practitioner's performance rather than to discipline the practitioner, although there are consequences for failure to improve performance. The Medical Staff Executive Committee may request evaluations of practitioners privileged through the medical staff process in instances where there is doubt about an applicant's ability to perform the privileges requested. The Focused Reviews will be conducted by the Medical Staff Executive Committee under the following circumstances:

- a. When undesirable patterns of performance compared to the practitioner's peer



- group are identified.
- b. When single events related to significant deviations from accepted standards of care are identified.

These patterns or single events would be identified through supervision, data reports from hospital or Medical Staff committees, or complaints from staff or patients. The Medical Staff Executive Committee will evaluate the appropriateness of any complaints, questions, or requests for corrective action and will recommend corrective action when warranted. The Medical Staff Executive Committee will make recommendations to the Clinical Director and the chairperson of the Credentials Committee regarding its findings.

The Focused Review will be performed by an ad hoc investigating Committee appointed by the President of the Medical Staff and the Medical Staff Executive Committee.

- 6. Accreditation – To remain familiar with all matters pertaining to certification and accreditation standards and to disseminate all such information through appropriate channels to the full Membership with such recommendations as are pertinent.
- 7. The President of the Medical Staff shall appoint a Bylaws Committee to review the SHC Medical Staff Bylaws at least every two years and whenever appropriate to revise and amend the Bylaws. The President of the Medical Staff or designee is the chairperson of the Bylaws Committee and shall preside over this committee.
- 8. The Medical Executive Committee may create or adopt policies for the Medical Staff that address areas outside and/or further clarifying these Bylaws, Rules & Regulations or otherwise provide further guidance for the fulfillment of the responsibilities of the medical staff.
- 9. The Medical Staff Executive Committee shall meet at least monthly and maintain a permanent record of its proceedings and actions.

**5.2.2 - Credentials Committee** - The Credentials Committee shall consist of at least three voting Members of the active Medical Staff. The Committee shall: investigate the credentials of all qualified applicants who are able by law to practice independently; recommend approval of clinical privileges consistent with the practitioner's experience and education, and make other recommendations in conformity with these Bylaws.

Additional duties include a review at least once every two years of each Member with recommendations for reappointments and privileges to be granted. The Credentials Committee meets as often as needed during the year and makes its recommendations at least twice per year, consistent with the credentialing and privileging process. The Committee shall send copies of its recommendations and reports to the Medical Staff Executive Committee, the Clinical Director, and CEO. The Committee shall keep records of the meeting.

**5.2.3 - Medical Records Committee** - The Medical Records Committee shall be chaired by a physician Member of the Medical Staff. Members shall include representatives from the Medical Staff (psychiatric and medical), nursing, social work, rehabilitation, psychology and the Director of Health Information Services (HIS) or

her/his designee. The Director of the HIS shall serve as the recording secretary.

The functions of this Committee shall be to:

1. Review inactive medical records at least monthly, to evaluate the quality and accuracy of documentation. The Committee is to assure that the medical records reflect the diagnosis, results of tests, the therapy rendered, the condition and in-hospital progress of the patient, and the condition of the patient at the time of discharge. The Committee is also to review summary information regarding the timely completion of all records. The criteria to be used in record reviews shall be CMS and Joint Commission standards on care, treatment and services and per hospital policy. The Committee may devise a form to facilitate the review process.
2. Report the review findings and recommendations to the appropriate individuals or committees as a feedback mechanism to facilitate corrective action when needed. The Committee may require a response in order to ascertain the corrective action has been taken.
3. Prepare a report of other problems identified at the records review including outstanding, incomplete, inactive records and reasons for delay in completing them. These reports and recommendations shall be sent to the Medical Staff Executive Committee, CEO, Clinical Director, and the Clinical Department Directors.
4. Approve all forms to be included in the clinical record and any changes in its format.
5. Review and approve proposed abbreviations as well as review the abbreviations list annually.
6. Maintain the list of do not use abbreviations.
7. Maintain written minutes of its conclusions, recommendations, actions and the results of its actions and send these approved minutes to the Medical Staff Executive Committee.

**5.2.4 - Infection Control Committee** - The Infection Control Committee consists of at least three Members: a chairperson, the Director of Medical Services or his/her designee; the Hospital Center Infection Control Coordinator; and a Department of Nursing staff Member. Representatives from Hospital Administration, Nursing Administration, Maintenance, Housekeeping, Laundry, Nursing, Pharmacy, Psychiatry and Dentistry act as consultants to the Committee. The Committee shall keep records of the meeting.

The function of this Committee shall be to:

1. To review data gathered by the Infection Control Coordinator on both nosocomial infections and significant non-nosocomial infections occurring within the hospital.
2. To recommend control policies relating to the control of infections within the facility.
3. To communicate policies to key hospital personnel as necessary. The Infection Control Committee Chairperson or in his/her absence the Director of Medical Services and/or the Clinical Director has the authority to implement any measures determined necessary to control any outbreak of infectious disease within the facility. The Committee will also cooperate with the administrative agency of the hospital, which collects and reports data on communicable disease. The Committee shall

meet at least every other month. Copies of minutes with recommendations will be sent to the Medical Staff Executive Committee.

**5.2.5 – Pharmacy and Therapeutics** – The Pharmacy and Therapeutics Committee shall include the Pharmacy Director, one psychiatrist, one somatic physician and at least one nursing staff representative. The Pharmacist shall be the secretary and the Committee shall be chaired by a physician. The Committee shall meet at least quarterly and shall keep records of the meetings.

The functions of the committee shall be:

1. To develop and approve policies and procedures relating to the selection, distribution, handling, use and administration of drugs and diagnostic testing materials.
2. To make a review of recent drugs and complications, recommend drugs or introduction of drugs for the Formulary, see that the Formulary is compiled and maintained current, maintain surveillance over the control of narcotics, sedatives and other dangerous drugs used in the hospital, and recommend policies, when needed.
3. To define and review all significant untoward drug reactions.
4. To monitor and evaluate the prophylactic, therapeutic and empirical use of drugs to help assure that they are provided appropriately, safely and effectively.
5. To routinely collect and assess information in order to identify opportunities to improve the use of drugs and to resolve problems in their use.
6. To monitor and evaluate the use of selected drugs chosen because:
  - a. they tend to cause significant adverse reactions or to interact with other drugs in dangerous ways,
  - b. they are used in patients who are at high risk for the development of adverse reactions,
  - c. they have been so chosen by the Infection Control Committee or Quality Improvement, or
  - d. they are among the most frequently prescribed drugs.
7. To monitor and evaluate the use of drugs based on objective criteria it develops based on current knowledge, clinical experience, and relevant literature. It may use screening mechanisms to uncover areas for more intensive study.
8. To make written quarterly reports of its proceedings to the Clinical Director sending a copy to the physician chairperson of Quality Improvement. To keep minutes of its conclusions, recommendations and actions taken along with the results which occur as a result of its actions and send the approved minutes to the Medical Staff Executive Committee.
9. To ensure that the results of drug usage evaluations are considered in Medical Staff reappointments and renewal of privileges and in Physicians' Quality Improvement activities.

**5.2.6 - Continuing Medical Education Committee** - The Continuing Medical Education Committee shall consist of a physician chairperson and other Members who shall represent psychiatry, medicine, and other clinical disciplines. The chairperson shall be knowledgeable of the requirements for accreditation of the Continuing Medical Education program according to the standards of the Accrediting Council for Continuing

Medical Education of the American Medical Association and the Continuing Medical Education Review Committee of the Medical and Chirurgical Faculty of Maryland.

The duties of this Committee shall be to plan and prepare educational programs, including facility-based programs that are related, at least in part, to the type and nature of care offered by the hospital, its Quality Improvement findings, and the expressed educational needs of individuals with clinical privileges. The program shall meet the "proposed regulations for Continuing Medical Education of the Board of Medical Examiners of the State of Maryland" as to the specifics regarding the hours and categories of required education. The committee shall also prepare an application to ensure approval of the program for accreditation by the Medical and Chirurgical Faculty of the State of Maryland. Its primary purpose is to provide opportunities for each individual with delineated clinical privileges to participate in continuing educational activities, which relate at least in part to the privileges granted. It shall make recommendations regarding the educational standards of Members and shall be responsible for keeping documentation of the continuing medical education activities of each Medical Staff Member, so that this can be considered when reappointment or renewal of clinical privileges is due. The Committee shall meet at least once every two months. The committee shall keep a record of the meeting and send a copy of the minutes to the Medical Staff Executive Committee.

**5.2.7 – Physicians’ Quality Improvement Committee** - The Members of the Physicians’ Quality Improvement Committee are composed of a physician Chairperson, the Associate Clinical Director, the Director of Medical Services, three (3) appointed Medical Staff Members. The Committee shall review all major clinical functions of the Medical Staff, considering the high volume and high-risk activities. The process shall include the systematic collection of data about important aspects of patient care provided by Medical Staff Members and about their clinical performance, with periodic assessment to identify problems and opportunities to improve patient care.

Objective criteria which reflect current knowledge and clinical experience shall be utilized to evaluate the quality of care, whenever applicable. When problems or opportunities to improve care are identified, recommendations will be made to the President of the Medical Staff, Medical Staff Executive Committee and the Clinical Director who will ensure that appropriate action is taken. All corrective actions shall be documented and evaluated for effectiveness according to the determined need for promptness of action (e.g., those affecting life or safety need immediate action). Its findings and conclusions, actions, and the impact of its actions are documented and reported monthly to the President of the Medical Staff, the Clinical Director, the Directors of Medical Services, the Associate Clinical Director, and the Members of this committee. All quality improvement findings shall be considered in the clinical privileging process. Findings of the Physicians’ Quality Improvement Committee are non-discoverable by law. The committee shall keep a record of the meeting.

**5.2.8 - Utilization Management Committee** - The Utilization Management Committee shall be chaired by a psychiatrist Member of the Medical Staff. Members shall include at least two other physicians, (one of them from Medical Services) and representatives

from Nursing, Social Work, Rehabilitation, Psychology, Medical Records, and Utilization Management staff.

The functions of this Committee shall be:

1. To review data on the appropriateness of patient levels of care.
2. To review data on readmissions.
3. To review staff compliance with hospital policies regarding documentation of patient care, with monthly feedback to appropriate administrative staff (Department Directors, Program Directors, Associate Clinical Director and the Director of Medical Services).
4. To identify potential problems with underutilization, over utilization, or inefficient use of hospital resources, with appropriate communication to administrative staff.

In addition, the staff of the Utilization Management Department performs designated screening of active medical records for the Medical Staff regarding quality of care, using approved screening criteria. The Committee maintains written reports of its monthly meetings, including all findings and recommendations which are reported to the President of the Medical Staff, Clinical Director, Department Directors, Hospital Administration, Members of this committee, and the Medical Assistance Compliance Office, as required by State regulation.

**5.2.9 – Special (Ad Hoc) Committees** – The President of the Medical Staff and/or the Clinical Director may appoint and define the role of other committees as may be necessary to allow the Medical Staff to participate in other review activities such as disaster planning, hospital safety, strategic planning, and/or utilization review. Should such a committee become a perpetuating or a standing committee of the Medical Staff, it shall be made so by amendment to the Bylaws of the Medical Staff.

#### **5.2.10 – Committee Activities**

**5.2.10.1** - All committees must keep accurate, pertinent records reflecting committee transactions, which will be submitted to the Medical Staff Executive Committee and the Clinical Director for review. All minutes and related correspondence shall be maintained in the files of the Department of Psychiatry and Medicine.

**5.2.10.2** - The CEO or his/her representative may attend all standing committee meetings to maintain proper communication for effective actions on policies and decisions, unless areas of confidentiality mandate a change in this process.

**5.2.10.3** - All Members of the Medical Staff shall be responsible for participating in committee activities as requested.

**5.2.10.4** - Committee Members shall be expected to attend three-quarters of the meetings of the committee to which he/she has been assigned. Any Member of the

Medical Staff who is required to be absent from a scheduled committee meeting shall notify the committee chairperson of his/her expected absence. Failure to meet attendance requirements without adequate justification shall be grounds for corrective action. Attendance will also be considered as part of the re-privileging process.

5.2.10.5 - A quorum is fifty per cent (50%) of the committee Membership, and if a quorum is present, any action taken by the majority shall be official.

5.2.10.6 - The number described in each appointed committee shall be considered to be the minimal number for each committee. Additional Members may be appointed by the Clinical Director and/or the President of the Medical Staff for special needs. Every appointed Member will be a voting Member of each committee.

## **ARTICLE VI – MEDICAL STAFF MEETINGS**

### **6.1 – Regular Meetings**

Monthly meetings of the Medical Staff, not less than twelve in each calendar year, are required. In addition to matters of organization, the agenda of such meetings must include reports from the Medical Staff Executive Committee and other Medical Staff committees. Minutes of all meetings of the Medical Staff will be recorded by the President of the Medical Staff. Copies of the minutes shall be distributed to the Members of the Medical Staff and the SHC Executive Council.

### **6.2 – Annual Meetings**

At the last meeting before the end of the fiscal year of the hospital, the committees shall make such reports and mandates as may be desirable and required. Medical Staff Executive Committee Members for the ensuing year (July - June) shall be elected.

### **6.3 – Special Meetings**

Special meetings may be called as necessary by the President of the Medical Staff. Morbidity and Mortality Conferences or Case Conferences shall be held at least monthly. Members of the Medical Staff shall be encouraged to attend other educational and interdisciplinary meetings.

### **6.4 - Notice**

Due notice of all regular and special meetings shall be given.

### **6.5 – Attendance at Meetings**

Attendance shall average at least fifty per cent of the active staff who are not excused by the Medical Staff Executive Committee for just cause. For the individual Member, unexcused absences for more than one-quarter of the regular meetings for the year,

may call for appropriate departmental action. All Members with provisional privileges are expected to attend meetings with the same regularity as Members of the active staff.

## **6.6 - Quorum**

Fifty per cent of the total Membership of the Medical Staff shall constitute a quorum. Written proxy votes will be accepted as valid in order to establish a quorum and to conduct regular business of the Medical Staff. Proxy votes must be in writing, dated and signed by the individual, for a specific Medical Staff meeting and indicate the person to whom the proxy has been given. They are only valid for that particular meeting and must be submitted to the Treasurer.

## **6.7 - Agenda**

The agenda at any regular meeting shall be:

1. Call to order and recording of attendance,
2. Approval of minutes of the last regular and of all special meetings,
3. Reports from the Clinical Director/Designee and Directors of Medical Services,
4. Old business,
5. Announcements by President,
6. Reports of Committees,
7. New business,
8. Adjournment.

## **6.8 – Member Rights**

1. In the event a Member of the Medical Staff is unable to resolve a specific issue regarding a rule, regulation or policy with the appropriate Medical Staff Committees, that Member may submit a written request to meet with the Medical Executive Committee (MEC) to discuss the issue.
2. The Medical Staff may also directly propose Medical Staff Bylaws, rules, regulations and policies to the governing body, independent of the Medical Executive Committee involvement.
3. Any Member of the Medical Staff may call a general Medical Staff meeting by presentation of a petition signed by at least twenty-five percent (25%) of the Medical Staff. The President of the Medical Staff will schedule a general staff meeting for the specific purpose requested by the petitioners. The petitioners may propose action by the Medical Staff to revise the authority the Medical Staff has delegated to the MEC or to reverse an action, or a proposed action, of the MEC. A simple majority of votes cast by the Members of the Medical Staff present is required to revise the authority granted to the MEC or to reverse an action, or proposed action of the MEC.
4. Any Member of the Medical Staff may raise a challenge to any rule, regulation or policy of the Medical Staff by submission of a petition signed by ten percent (10%) of the Medical Staff. Upon receipt of such a petition, the MEC will either: (1) provide the petitioner's with information clarifying the intent of such rule, regulation or policy:

- and/or (2) schedule a meeting with the petitioners to discuss the issue.
5. If the Medical Staff and MEC are unable to resolve the conflict/issue/disagreement, the Medical Staff or MEC may request that SHC Executive Council review the matter and serve as an arbiter. If the decision of the SHC Executive Council does not resolve the concerns of the Medical Staff or MEC, the BHA Facilities Governing Body will serve as the source of the final appeal of the decision.

## **6.9 - Authority**

Authority in reference to these Bylaws and for parliamentary procedures at any meeting shall be: "Roberts Rules of Order, Revised".

## **6.10 – Communication With Hospital Administration, SHC Executive Council and MHA Facilities' Governing Body**

6.10.1 - The President of the Medical Staff reports directly to the Clinical Director who in turn reports to the CEO. The Clinical Director is a Member of the Medical Staff and may attend its meetings.

6.10.2 - The CEO has an ex-officio position on each committee. In addition, the Medical Staff, by a majority vote of any meeting in which there is a quorum, may request the CEO to attend the next meeting.

6.10.3 - The Medical Staff may ask for representation from the BHA Facilities' Governing Body at one of its meetings by writing to the BHA representative who is responsible for SHC.

6.10.4 -- Relevant reports of any Medical Staff committee are to be shared with the SHC Executive Council, when such action is required by the Governing Body's Bylaws or by State law.

6.10.5 - The Clinical Director, or his/her designee, attends the monthly State-wide Clinical Director's Meetings, whose Chairperson is a Member of the BHA Facilities' Governing Body.

6.10.6 - The President routinely makes recommendations to the Clinical Director and may ask that important issues be forwarded through appropriate channels to the SHC Executive Council or BHA Facilities' Governing Body.



# **ARTICLE VII – CORRECTIVE ACTIONS, SUSPENSIONS AND RIGHTS OF APPEAL**

## **7.1– Request for Corrective Action**

Whenever the prior or present activities or professional conduct of any practitioner with clinical privileges are considered to be lower than the standards or aims of the Medical Staff, a complaint against such practitioner may be filed by the President of the Medical Staff, the Associate Clinical Director, the Director of Medical Services, the Chairperson of any standing committee of the Medical Staff, the Clinical Director, the CEO, the SHC Executive Council, or the Governing body of BHA. All complaints shall be in writing, shall be made to both the Clinical Director and the President of the Medical Staff, and shall be supported by reference to the specific activities or conduct which constitutes grounds for the complaint. The person filing the complaint may request rejection or corrective action. In response to a complaint, the President of the Medical Staff shall notify the Medical Executive Committee.

1. If the corrective action would not require a reduction or suspension of clinical privileges, then, with the agreement of the MEC, the President may either appoint an Ad Hoc Committee to investigate the complaint or refer the matter to the practitioner's immediate supervisor. The Ad Hoc Committee or the supervisor shall report the findings and recommendations (for rejection, for corrective action, for a counseling memorandum, or for dismissal of the complaint) to the President of the Medical Staff and the Clinical Director within two weeks. The MEC has 30 days from the receipt of a complaint to submit a final report of findings and recommendations to the Clinical Director.
2. If the corrective action could include a reduction or suspension of clinical privileges, the MEC shall immediately meet to investigate the matter. The practitioner shall immediately be notified in writing by the President of the Medical Staff and the MEC of the complaint. The possible corrective action and the responsibility of the MEC to investigate must be explained, along with the right of the practitioner to appeal the corrective action. The practitioner shall have the opportunity for an interview with the MEC. At this interview s/he shall be informed of the general nature of the complaint and shall be invited to discuss, explain, or refute the complaint; the MEC must consider any mitigating circumstances. This interview shall not constitute a hearing; it shall be preliminary in nature. This interview must occur prior to the submission of the report by the MEC to the Clinical Director; this report must be submitted within 30 days of a complaint.

## **7.2– Actions by Medical Staff Executive Committee**

The MEC investigation of a complaint may lead to a number of recommendations to the Clinical Director, including but not limited to:

1. Rejection or modification of the request for corrective action.
2. Issuance of a counseling memorandum, a letter of admonition, or a letter of reprimand.
3. Imposition of a period of probation.
4. Requirement for consultation.
5. Reduction, suspension, or revocation of clinical privileges.
6. Termination, modification, or sustainment of an already imposed summary suspension.
7. Suspension or revocation of medical staff membership.

A counseling memorandum or a letter of reprimand or a letter of admonition is an instructional communication and is not a disciplinary action. Within 5 days of receiving a counseling memorandum or letter of admonition or reprimand, a practitioner may submit a written response to the memorandum which should be placed in the employee file and attached to any record of the memorandum.

Any recommendation by the MEC for reduction, suspension, or revocation of clinical privileges or for suspension or expulsion from the Medical Staff, shall entitle the affected practitioner to the procedural rights stated in the Maryland State Annotated Code (see Rights of Appeal). The practitioner is entitled to the Fair Hearing Process described in section 3.3.5. If the practitioner fails to appeal, s/he is considered to have accepted the decision.

### **7.3 - Rights of Appeal**

The State employee's rights are described in the DHMH regulations (Michie's Annotated Code of the Public General Laws of Maryland, 2009 edition) under Title 5: Employee Rights and Protections, Title 11: Disciplinary Actions, and Title 12: Grievance Procedures. These sections describe the procedures for the appeal process, which must be done in a timely manner, usually within 15 days. The appeal procedures are given to the practitioner in writing at the time of the disciplinary action.

## **ARTICLE VIII – PHYSICIAN HEALTH**

### **8.1 - Education**

The Medical Staff, LIPs, and the organization staff will be educated regarding illness and impairment recognition issues specific to physicians and LIPs. Education pertinent to the issue of physician impairment will be provided to all staff at appropriate reading levels through presentations at general staff meetings, educational fliers distributed at annual training day, and selected topics presented at psychiatric grand rounds. There will be an annual program that provides education about LIP health, addresses prevention of physical, psychiatric, or emotional illness, and facilitates confidential diagnosis, treatment, and rehabilitation. All new Members of the Medical Staff will be provided information about physician health.

## 8.2 – Referral

Self-referral by a Physician or Referral by Other Organization Staff: Any Member of the medical staff who is concerned about their own health may refer him or herself for assistance. Any member of the medical staff who is concerned about another physician's behavior because of suspected alcohol and or any substance abuse, mental or emotional problems, physical impairment, sexual misconduct, disruptive behaviors, unusual stress and/or any other matter which is considered to interfere with the capacity of the physician to properly discharge his/her responsibilities to his/her patients is expected to immediately communicate the concern to one or more of the following; the physician's supervisor, the Associate Clinical Director, the Clinical Director, or to the President of the Medical Staff. The physician will be provided all necessary information for referral to a Physician Rehabilitation Program. Maintenance of the confidentiality of the physician seeking referral or referred for assistance, except as limited by law, ethical obligation, or when the safety of a patient is threatened will be observed.

## 8.3 – Process

Process of Referral for Consultation: The medical staff implements a process to identify and manage matters of individual health for licensed independent practitioners. Any Member of the staff who has reason to believe and/or observes a physician exhibiting behavior that is considered inappropriate behavior to permit the adequate performance of his/her duty to patients may communicate such concern to one or more of the following; President of the Medical Staff, the Associate Clinical Director, the Clinical Director or to the physician's immediate supervisor. If the physician's immediate supervisor, the Associate Clinical Director or the Clinical Director, receives the complaint, they will promptly communicate to the President of the Medical Staff who then will inform the Medical Staff Executive Committee. The President of the Medical Staff will promptly meet with the physician for the purpose of ascertaining the urgency of the request and determine the need for intervention. The identity of the informant(s) will remain confidential. The Clinical Director will be fully informed and apprised of all information available. The affected physician will be asked to meet with the Medical Staff Executive Committee for discussion of the allegation and assessment of his/her physical and emotional condition as it pertains to the proper discharge of privileges to treat patients. The President of the Medical Staff will convene a meeting of the Medical Staff Executive Committee in order to discuss the preliminary information and take any necessary immediate action to ensure patient safety. The credibility of the complaint, allegation, or concern will be an important part of the Medical Staff Executive Committee evaluation. The Clinical Director and CEO will be immediately apprised of the results of the investigation of the Medical Staff Executive Committee and the recommendations for further action. The physician will be referred to an appropriate professional internal and external resource for evaluation, diagnosis, and treatment of the condition or concern. Periodic reports from the treating agent and the physician's supervisor outlining progress of treatment, and/or the Medical Staff Executive Committee, when applicable, will be incorporated in the physician's credentials file. The progress of treatment will determine any limitation in the privileges of the physician. The Maryland Board of Physicians and the National Practitioner Data Bank will be informed

only as required by law. All information pertaining to the matter shall be considered confidential and will be kept in a locked file at the Medical Staff office. All information pertaining to physician health in the Credentials Committee shall be kept in a separate file and labeled as confidential. Any information to be released will require the written permission of the physician except whenever mandated by law. The physician's supervisor, Clinical/Associate Director's office and the Medical Staff Executive Committee will maintain an ongoing monitoring of the affected physician and the safety of patients until the rehabilitation or any disciplinary process is complete. Failure to comply with the rehabilitation program or disciplinary process will invoke the corrective action process described in section 7.1 (Rejection or Corrective Action) and 7.2 (Process) and may lead to suspension as described in section 7.3 (Summary Suspension).

## **ARTICLE IX – IMMUNITY FROM LIABILITY**

### **9.1 - Description**

In accordance with provisions of the Maryland Annotated Code, the following persons have the immunity described below:

#### Providing information about another physician:

The following persons are not civilly liable for giving information to any hospital, hospital medical staff, related institution, health care facility, alternative health system, professional society, medical school or professional licensing board:

1. The Hospital's Chief Executive Officer,
2. Members of the Hospital's staff and credentials committees, and
3. Physicians with privileges at Springfield Hospital Center.

As long as the person gives the information in good faith and with the intention of aiding in the evaluation of the qualifications, fitness or character of a physician and does not represent as true any matter that the person does not reasonably believe to be true.

References: Md. Ann. Code, Health-Occupations Article, §14-502(b)(5), (6), (7); Courts & Judicial Proceedings Article, §5-638(b).

#### Medical Review Committees:

A person who acts in good faith and within the scope of the jurisdiction of a medical review committee is not civilly liable for any action as a member of the Medical Review Committee or for giving information to, participating in, or contributing to the function of the Medical Review Committee.

References: Md. Ann. Code, Health-Occupations Article, §1.401(f); Courts & Judicial Proceedings Article, §5-637.

## **ARTICLE X – ADDITIONAL PROVISIONS**

### **10.1 – Dues or Assessments**

The Medical Staff shall have the power to recommend the amount of annual dues or assessments, if any, for each category of Medical Staff Membership, subject to the approval of the Medical Staff, and to determine the manner of expenditure of such funds received.

### **10.2 – Present Dues**

The present dues are \$50.00 per year full-time or \$25.00 per year half time which are payable by January 1. If not paid by February 1, a note of delinquency will be forwarded to the Medical Executive Committee. Failure to pay dues shall result in a restriction or suspension of clinical privileges and is a reportable event to the Maryland Board of Physicians.

### **10.3 – Construction of Terms and Headings**

The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope of or affect any of the substantive provisions of these Bylaws. These Bylaws apply with equal force to both sexes wherever a gender term is used.

### **10.4 – Authority to Act**

Any Member or Members who act in the name of this Medical Staff without proper authority shall be subject to such disciplinary action, as the Medical Executive Committee may deem appropriate.

### **10.5 – Admissions**

10.5.1 – Patients are admitted according to state law and hospital policies.

10.5.2 – An admission note shall be prepared at the time of admission, according to hospital policy.

10.5.3 - Dental examination shall be completed within 30 days of admission for adults and within 8 days of admission for patients below the age of 18. This will follow general hospital current policy.

## **10.6 – Physicians’ Orders**

10.6.1 - Physicians’ orders shall comply with hospital policies.

1. They shall be formulated and reviewed at least every 30 days, and shall be signed and dated by the unit physician and/or by the reviewing physician.
2. Physicians’ orders for seclusion and restraint shall follow guidelines in hospital policy.
3. All physicians’ telephone orders are given only to a registered nurse and must be cosigned within 24 hours per hospital policy. This will follow general hospital current policy.

## **10.7 – Pharmacy - Formulary**

10.7.1 - **Drugs Used** - Drugs used shall be those listed in the United States Pharmacopoeia, National Formulary, New and Non-Official Remedies, with the exception of drugs for bona fide clinical investigations. Exceptions to this rule shall be justified and approved by the Clinical Director.

10.7.2 - **Automatic Stop Orders** - On Toxic or Dangerous Drugs - Controlled Substances Category II to IV, anticoagulants and antibiotics, if ordered without specific time limitations, shall be discontinued automatically as follows:

1. Controlled substances Category II to IV, after 24 hours;
2. Antibiotics, after 7 days. These drugs shall not be discontinued without notification of the physician in charge.

## **10.8 - Medical Records**

10.8.1- The Chairperson of the Medical Records Committee shall have shared responsibility for the completeness of the medical record for each patient.

10.8.2 - **Content** - All records shall comply with hospital policy, and shall include identification data, preferred language, complaint, personal history, family history, substance use history, history of the present illness, physical examination and mental status. It should also include special reports such as consultations, clinical laboratory, x-ray and others, provisional diagnosis, psychiatric treatment, medical-surgical treatment, operative report, pathological findings, progress notes, final diagnosis, condition on discharge, summary on discharge, follow-up and autopsy report (when available).

10.8.3 - No medical record shall be filed until it is complete, except on order of the Medical Records Committee.

**10.8.4 - Progress Notes** - Frequency of progress notes is determined by the condition of the patient, but at a minimum shall be in compliance with hospital policy.

**10.8.5 - Individual Plan Of Care (IPOC)** - Upon admission and initial evaluation of any patient, the attending physician will write a brief treatment plan which will be recorded in the patient's record within the first 24 hours. Subsequent treatment plans will be developed according to hospital policy.

**10.8.6 - Medical History and Physical Exam** – A medical history and physical examination must be completed and documented for each patient within 24 hours after admission. The medical history and physical examination must be completed and documented by a qualified licensed physician in accordance with State and federal law, as well as these Bylaws and the Medical Staff Additional Provisions. Whenever a medical history and physical examination has been completed within 30 days prior to admission, an updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission. The updated examination, including any changes in the patient's condition, must be completed and documented by a qualified licensed physician as described in section 4.1.8.5 and 10.9.6. Additional requirements for completing a medical history and physical examination are set forth in the Medical Staff Policy. Frequency and content of medical history and physical exams is determined by the condition of the patient, but at a minimum shall be in compliance with Medical Staff policies on Admission Assessment and Annual Assessment. The minimal content of medical histories and physical examinations are further specified in the Admission and Annual Assessment forms.

**10.8.7** - Records shall be kept on all treatment procedures.

**10.8.8** - All records are the property of the hospital and may only be removed from the hospital's jurisdiction and safe keeping in accordance with a court order, subpoena or statute. In case of readmission, all previous records shall be available for use by the attending physician.

**10.8.9 - Access** - Free access to all medical records shall be accorded to staff physicians and dentists in good standing for bona fide study and research, consistent with preserving the confidentiality of personal information concerning the individual patients. Subject to the discretion of the Clinical Director, former Members of the Department shall be permitted free access to medical records of their patients covering all periods during which they attended such patients in the hospital.

**10.8.10 - Symbols and Abbreviations** - Only those symbols and abbreviations authorized by the Medical Records Committee shall be used.

10.8.11 - The medical record shall be complete within 30 days following discharge of the patient or shall be considered delinquent. The discharge summary shall be dictated within seven (7) days or typed within fourteen (14) days following discharge of the patient or shall be considered delinquent.

10.8.12 - All entries in the patient's record must be dated/timed and authenticated by the responsible practitioner, per hospital policy.

10.8.13 - Medical Records Committee shall identify those practitioners who continuously fail to follow the policy for timeliness and report to Clinical Director for action.

## **10. 9 – Physician’s Responsibilities**

10.9.1 - A licensed physician shall be responsible for the diagnostic evaluation and all medical care and treatment for each patient. All multidisciplinary treatment plans must be signed by at least one physician, in order to assure appropriate physician involvement and approval.

10.9.2 - **Attending Psychiatrist** - Staff psychiatrist responsible for the total care of each psychiatric patient assigned to him or her. Duties and responsibilities include admission, assessment, treatment, transfer and discharge of assigned psychiatric patient. The attending psychiatrist is also the team leader responsible for leading and coordinating a multi-disciplinary team that assists him or her in the assessment, treatment planning, treatment, and release of the assigned psychiatric patients.

10.9.3 - **Psychiatry Resident/Fellow** - If the psychiatrist assigned to care for a patient is a Resident or Fellow in training, he/she must have a supervisor who is responsible for the patient's care and this must be documented in the patient's record.

10.9.4 – **Consultants/Adjunct Staff** – Although judgments regarding diagnosis and treatment rest with the physician responsible for the care of the patient, Members of the Medical Staff should not fail to obtain consultation when needed. A satisfactory consultation includes examination of the patient and the record and a written opinion and recommendations signed by the consultant, which is made part of the record. When operative procedures are involved, the consultation note, except in emergency, shall be recorded prior to the operation. These practitioners will provide care, treatment and services within the scope of their privileges.

10.9.5 - **Officer of the Day (SPOD/POD)** - A regular schedule, assigning physicians as Officers of the Day, shall be maintained. Under no circumstances may the officer of the day leave the hospital unless properly relieved by a qualified physician. Emergency care, unless otherwise covered by policies and procedures approved by the hospital, is the responsibility of these Officer of the Day physicians, as described in their scope of privileges and job description.



**10.9.6 – Primary Care Physicians/Somatic Physicians–** All primary care/somatic physicians are responsible for providing a uniform standard of quality patient care and medical treatment to the assigned patients within the scope of their privileges.

1. The medical history and physical examination must be placed in the patient's medical record within 24 hours of admission.
2. When the medical history and physical examination are completed within 30 days before admission, an updated medical record entry documenting an examination for any changes is completed. This updated examination must be completed and documented in the patient's medical record within 24 hours of admission.
3. In the case of highly disturbed or very uncooperative patients on whom a complete physical examination cannot be done, then a description including observation of the patient, medical record review and/or interview of the patient is completed. The physician responsible for performing the physical examination must make every reasonable effort to do a complete physical examination as soon as possible, and such efforts shall be documented in the patient's records weekly. If a patient who has not had a complete physical examination is transferred to another area of the hospital, it shall be the responsibility of the newly assigned primary care physician to assure that the examination is done.

## **10.10 - Transfers**

10.10.1 - Transfer between units within the hospital shall be in accordance with hospital policy on such transfers.

10.10.2 - Transfers to other hospitals shall be in accordance with hospital policy on such transfers.

**10.11 – Electroconvulsive Therapy (ECT)** - Electroconvulsive Therapy (ECT) is not performed at SHC, but patients may be referred to another institution for this treatment. The hospital's Plan for Referral and Monitoring of ECT shall be followed.

## **10.12 – Discharges**

10.12.1 - **Order** - Patients shall be discharged only on the written order of a staff physician.

10.12.2 – **Records** - At the time of discharge, the physician shall see that the record is complete.

**10.13 – Dentists** - All dentists shall conform to the Medical Staff Bylaws, and Departmental Policies and Procedures, with the following additions:

10.13.1 - Patients who require oral surgery are to be referred to the office of a qualified oral surgeon for evaluation and/or treatment.

10.13.2 - Restorative and preventive dentistry as well as dental surgery are performed in the dental office, and are the responsibility of the individual dentist.

10.13.3 - Complete dental records are required on each dental patient and are to become a part of the patient's record.

**10.14 – Podiatrists** - All podiatrists shall conform to the Bylaws, Departmental Policies, and Procedures, with the following additions:

10.14.1 - A qualified Member of the Medical Staff must be responsible for the care of any medical problems. The podiatrist shall be responsible for any intervention for which he/she is qualified, privileged and legally licensed to perform.

10.14.2 - All podiatric interventions on a patient require adequate written documentation, which shall become a part of the patient's record.

10.14.3 - Qualified podiatrists may be given any or all of the following privileges by the Department of Medicine:

1. The podiatrist may prescribe systemic medication as permitted by law and as deemed necessary in the treatment of foot diseases.
2. The podiatrist may administer local anesthesia in the consultation room assigned for the examination in order to perform minor surgical procedures on the foot.

10.14.4 - All podiatric procedures should be performed in an assigned room.

10.14.5 - Referral to the podiatrist will be made only by the attending physician or somatic physician.

**10.15 – Resignation and Retirement** - All Members of the department must obtain clearance from Health Information Services (regarding completion of their records) before their final day of employment.

**10.16 – Practice, Laws and Regulations** – The practice of every clinician within the hospital shall conform to:

1. The appropriate laws and regulations of the State of Maryland.
2. Local and State Medical Society guidelines, where appropriate, the American Medical
3. Hospital policies.

**10.17 – Definitions and Guidelines for Supervision, Consultation and Collaboration**

10.17.1 - A supervisory relationship between a psychiatrist and a non-physician mental

health therapist is defined as an ongoing relationship in which the psychiatrist provides professional direction and active guidance to the therapist in the conduct of the patient's care. As such, the psychiatrist is responsible for personally conducting the initial workup, diagnosis and prescription of a treatment plan for the patient. Such a psychiatrist remains ethically and medically responsible for the patient's mental health care as long as the prescribed treatment continues under his/her supervision.

10.17.2 - A consultative relationship between a psychiatrist and a non-physician mental health therapist is defined as a relationship in which the psychiatrist provides professional advice and opinion for the therapist with regard to the patient's care on a one-time, periodic or ongoing basis. Such advice and opinion may or may not be implemented by the therapist. Therefore, in the consultative relationship, while the psychiatrist should keep generally informed about the conduct of the therapy, he/she is not ethically or medically responsible for the conduct of the patient's care, and the ethics of the therapist's discipline apply.

10.17.3 - Collaboration involves situations in which the psychiatrist and non-physician therapist provide different but complementary functions relating to the patient's care. For example, a psychiatrist may prescribe medication while individual or group therapy may be provided by a psychologist, social worker or nurse as credentialed by the individual's department. In cases in which patients are receiving psychiatric medications and/or other somatic therapies, the psychiatrist remains medically responsible for the patient's care as long as the medical involvement lasts, while the responsibility of the collaborative professional follows his/her dictates. Collaboration may occur as a result of both supervisory and consultative relationships.

10.17.4 - It is unethical for the psychiatrist to continue a supervisory, consultative or collaborative relationship when he/she is convinced that the quality of the care being provided is unacceptable. Thus, the psychiatrist should undertake such relationships with a mental health therapist only if he/she is able to keep appropriately informed of the nature of the treatment and the progress of the patients, and can be assured that the treatment provided by the non-physician practitioner is being carried out competently and adequately.

10.17.5 - Because of the wide range of competence and training which currently exists among non-physician mental health therapists, it is incumbent upon the psychiatrist to provide an amount of supervision, consultation and/or collaboration sufficient to assure that his/her legal, ethical and medical responsibilities toward the patient are met.

## **ARTICLE XI – AMENDMENTS AND REVISIONS**

### **11.1 – Amendments and Revisions**

These Bylaws may be amended after initial presentation at any regular meeting of the Medical Staff. Proposed amendments shall be referred to the Medical Staff Executive Committee, which shall report at the next regular meeting. Two-thirds majority of voting

Members is required for adoption.

Written notice of any meeting at which amendments or revisions will be considered shall be sent to Members at least one month prior to the meeting, along with a copy of the proposed changes. Amendments and revisions approved by the above procedures become effective upon approval by the Medical Staff, Clinical Director, CEO and the SHC Executive Council and cannot be made unilaterally by the Medical Staff, Hospital Administration, or the SHC Executive Council. Amendments and revisions to these Bylaws shall be distributed to the Members of the Medical Staff and other individuals who have delineated clinical privileges.

These Bylaws and any policies promulgated under them, in order to reflect current practices, are to be reviewed no less than every two years; documentation of this review is to be made by the Medical Staff President and the CEO.

## **ARTICLE XII – ADOPTION**

**12.1 – General** - These Bylaws, together with any appended Policies and Procedures, shall be adopted at any regular meeting, shall replace any previous Bylaws and shall become effective when approved by the SHC Executive Council

## **APPENDICES**

**Appendix A:** Springfield Hospital Center Graduate Medical Education Programs.

**SPRINGFIELD HOSPITAL CENTER  
GRADUATE MEDICAL EDUCATION PROGRAMS**

**I. SCOPE**

This Medical Staff policy and procedure applies to all units of Springfield Hospital Center.

**II. DEFINITIONS**

- A. Participant in a Graduate Education Program - For the purpose of this policy and procedure, this means a medical student, a psychiatric resident, a psychiatric fellow or a PA Student.
- B. Post Graduate Year (PGY) - For the purpose of this policy and procedure, this means the year of postgraduate training for a physician or (osteopath) who is currently in a psychiatric residency- training program.
- C. Attending Physician - For the purpose of this policy and procedure, this means an active Member of the Medical Staff of Springfield Hospital Center (SHC) who holds current clinical privileges in psychiatry (see below for additional details).
- D. Medical Education Committee – For the purpose of this policy and procedure, this means a committee that oversees medical education at Springfield Hospital Center, composed of the Clinical Director, the Supervisor of Psychiatry Residency Training, the Supervisor of Medical Student Training, the Supervisor of Physician's Assistant Training, the Director of Forensic Psychiatry, and the President of the Medical Staff.

**III. PREAMBLE**

The management of each patient's care at Springfield Hospital Center, including the care of participants in professional graduate education programs, is the responsibility of a licensed independent practitioner who is a Member of the Medical Staff. Accordingly, the Medical Staff assures that each participant in a professional graduate education program is supervised in his/her patient care responsibilities by an active Member of the Medical Staff who has been granted clinical privileges by the SHC Governing Body, through the Medical Staff's process. Springfield does not independently offer a professional graduate education program, but instead, serves as an approved training site for one professional graduate educational institution, the University of Maryland, Baltimore, School of Medicine and Department of Psychiatry.

## **IV. POLICY AND PROCEDURE**

### **A. General**

1. Participants in professional graduate education programs at Springfield Hospital Center shall be supervised, by a licensed independent practitioner with appropriate clinical privileges, in carrying out all patient care responsibilities. In addition, it is the responsibility of the Medical Staff leadership to assure that the Medical Staff is provided with a written description of the role, responsibilities, and patient care activities of participants in professional graduate education programs (see below).
2. The level of supervision required and provided is based upon the following factors: The current level training, and the demonstrated preparedness of the participant to carry out specific patient care responsibilities. All patients at Springfield Hospital Center are assigned to an attending physician who is an active Member of the Medical Staff and who has privileges in psychiatry.
3. Oversight of professional graduate education at Springfield Hospital Center is provided by the Office of the Clinical Director and the Medical Staff Executive Committee.
4. As a condition of affiliation, a residency program must agree to continuously maintain accreditation by the Accreditation Council for Graduate Medical Education (ACGME).
5. The Medical Education Committee will meet at least annually to discuss the safety, treatment of, services provided by, quality of patient care, supervisory needs, and educational needs of the trainees. They will then prepare reports for Springfield's Medical Executive Committee, Springfield's Governing Body, and University of Maryland's Medical Education Committee on these same subjects.

### **B. Communication between the Medical Staff and the Governing Body Regarding Professional Graduate Education:**

1. It shall be the responsibility of the Clinical Director and Medical Staff Executive Committee to regularly communicate with the attending physicians who are designated by the Clinical Director and Medical Staff President to serve as supervisors of participants in professional graduate education programs about the safety and quality of patient care provided by, and the related educational supervisory needs of, the participants in the professional graduate education program.
2. A Member of the Medical Staff of Springfield Hospital Center shall, upon appointment by the Clinical Director and President, serve as the Medical Staff's and the Executive Council's liaison to the University of Maryland's Psychiatric Residency Training Program's Residency Education Committee, as well as to similar committees of any other ACGME accredited program with which the hospital may affiliate. Members of the medical staff shall be appointed to serve in a similar capacity as liaisons to the Clinical Coordinator/Director of the Physician Assistants school/program and to the Director of Medical Student Education. These liaisons shall be responsible

for communicating information about the safety and quality of patient care, treatment, and services provided by and the related educational and supervisory needs of the participants in professional graduate education programs.

3. The Clinical Director and Medical Staff Executive Committee shall assure that all residency training programs, with which Springfield Hospital Center is affiliated, including the University of Maryland's training program, shall continue to meet the requirements of the ACGME in order for the affiliation to continue. It shall also be the responsibility of the Clinical Director and Medical Staff Executive Committee to address and demonstrate compliance with any residency review committee citations related to these standards, as they pertain to the training experience at Springfield Hospital Center.
4. The Clinical Director and Medical Staff Executive Committee shall assure that all Medical/Physician Assistant student training programs, with which Springfield Hospital Center is affiliated, shall continue to meet the requirements of the appropriate accreditation body in order for the affiliation to continue. It shall also be the responsibility of the Clinical Director and Medical Staff Executive Committee to address and demonstrate compliance with any program review committee citations related to these standards, as they pertain to the training experience at Springfield Hospital Center.
5. The Clinical Director shall have the authority to immediately suspend or revoke an affiliation with a residency training program that has lost its ACGME accreditation. In addition, the Clinical Director and Medical Staff Executive Committee provide regular reports regarding the professional graduate education activities at Springfield Hospital Center to the SHC Governing Body in a timely manner. There shall be at least an annual written report, submitted to the SHC Governing Body by the Office of the Clinical Director and Medical Staff Executive Committee that summarizes the safety and quality of patient care provided by, and the related educational supervisory needs of, the participants in the professional graduate education program.

### **C. Psychiatric Residents in the First Year of Training:**

1. Qualifications - In order to participate as a psychiatric resident in the first year of training (PGY I) at Springfield Hospital Center, the resident must be an independently verified resident in good standing in the University of Maryland Psychiatric Residency Program, accredited by the Accreditation Council for Graduate Medical Education (ACGME), and with which Springfield Hospital Center has executed a formal agreement for this purpose. The resident must also be currently registered as an unlicensed medical practitioner with the Maryland Board of Physicians, with attestation provided by the director of residency training or designee of the resident's training program. Residency training experience at this level is provided only in Psychiatry.
2. Supervision - An active Member of the Medical Staff, who is a licensed independent practitioner, shall directly supervise these residents.

- a. The supervisor shall have current privileges to admit patients to Springfield Hospital Center; provide comprehensive psychiatric assessments and treatment plans; treat common psychiatric illnesses; assign psychiatric diagnoses; and provide psychiatric consultation to non-psychiatrist colleagues.
- b. The supervisor shall be appointed to these supervisory duties by the Clinical Director in consultation with the President of the Medical Staff. The supervisor's performance shall be assessed at least annually, usually as part of the supervisor's annual evaluation.
- c. Supervisors of a resident in the first year of residency training shall thoroughly assess the preparedness of the resident for progressive involvement and independence in specific patient care activities (consistent with the approved activities identified below) and the supervisor shall have the authority to modify, suspend or revoke all or part of the resident's roles, responsibilities and patient care activities in the event that the supervisor reasonably determines that the resident has proven ill-prepared to provide those services. In such instances, the supervisor promptly provides feedback to the residency-training program, the Clinical Director and the Medical Staff Executive Committee. The supervisor through regular and timely supervisory meetings accomplishes the assessment process with the resident. Cases assigned to the resident are thoroughly reviewed to assure that each patient is receiving medically necessary and appropriate treatment. Regular and timely medical record reviews of each of the cases assigned to the resident are conducted.

3. Roles, Responsibilities and Patient Care Activities of Residents in the First Year of Residency Training.

Under the careful oversight of the supervisor, these residents may:

- a. Perform psychiatric evaluations of newly admitted patients (after the patient has been evaluated and admitted by a Member of the Medical Staff with privileges to admit patients).
- b. Prescribe medications to treat a patient's mental illness and to treat routine somatic problems such as uncomplicated constipation or headache. NOTE: countersignature by a licensed independent practitioner is not required.
- c. Provide individual, group and family therapies and interventions.
- d. Participate as a Member of the patient's treatment team in the creation and implementation of the patient's Individual Plan of Care (IPOC).
- e. Make medical records entries, such as psychiatric admission assessments, physician progress notes and discharge summaries, in accordance with applicable Springfield Hospital Center policies.



(Psychiatric admission assessments and discharge summaries prepared by residents are reviewed and countersigned by the supervisor before they are entered into the medical record.)

- f. Assist in the supervision of Medical Students, under the direct oversight of the resident's supervisor (see below).
- g. NOTE: Residents in the first year of training may not order seclusion or restraint.

**D. Psychiatric Residents Who Are Beyond the First Year of Training (Including Psychiatric Fellows) Who are Unlicensed in Maryland or Not Otherwise Privileged as a Licensed Independent Practitioner at Springfield Hospital Center:**

1. Qualifications - In order to participate as a psychiatric resident who is beyond the first year of training (PGY II or greater) at Springfield Hospital Center the resident must be an independently verified resident in good standing in the University of Maryland Psychiatric Residency Program, accredited by the Accreditation Council for Graduate Medical Education (ACGME), and with which Springfield Hospital Center has executed a formal agreement for this purpose. The resident must also be currently registered as an unlicensed medical practitioner with the Maryland Board of Physicians, with attestation provided by the director of residency training or designee of the resident's training program. Or, if the resident is licensed but not otherwise privileged through the Medical Staff, independent verification of current licensure in the State of Maryland must be provided. Residency training experience is provided only in psychiatry for PGY II or III residents or in approved subspecialty areas (addictions, forensics, geriatrics) for PGY IV and PGY V residents.
2. Supervision - An active Member of the Medical Staff, who is a licensed independent practitioner, shall directly supervise these residents.
  - a. The supervisor shall have current privileges to admit patients to Springfield Hospital Center; provide comprehensive psychiatric assessments and treatment plans; treat common psychiatric illnesses; assign psychiatric diagnoses; and provide psychiatric consultation to non-psychiatrist colleagues.
  - b. The supervisor shall be appointed to these supervisory duties by the Clinical Director in consultation with the Medical Staff President. The supervisor's performance shall be assessed at least annually as part of the supervisor's annual evaluation.
  - c. The supervisor of the resident shall thoroughly assess the preparedness of the resident for progressive involvement and independence in specific patient care activities (identified below) and the supervisor shall have the authority to modify, suspend or revoke all or part of the resident's roles, responsibilities and patient care activities in the event that the supervisor reasonably determines that the resident has proven ill-prepared to provide

those services. In such instances, the supervisor promptly provides feedback to the residency training program, the Clinical Director, and the Medical Staff Executive Committee. The assessment process is accomplished through regular and timely supervisory meetings; regular and timely face-to-face contact with all patients as needed; and regular and timely review of the medical record of each of the cases assigned to the resident.

3. Roles, Responsibilities and Patient Care Activities of Residents Who Are Beyond the First Year of Residency Training, and Fellows (Unlicensed in Maryland, or Not Otherwise Privileged as a Licensed Independent Practitioner at Springfield Center):

Under the careful oversight of the supervisor, these residents may:

- a. Perform psychiatric evaluations of newly admitted patients (after the patient has been evaluated and admitted by a Member of the Medical Staff with privileges to admit patients).
- b. Prescribe medications to treat a patient's mental illness and to treat routine somatic problems such as uncomplicated constipation or headache. Note: Countersignature by a licensed independent practitioner is not required.
- c. Provide individual, group and family therapies and interventions.
- d. Participate as a Member of the patient's treatment team in the creation and implementation of the patient's Individual Plan of Care (IPOC).
- e. Make medical records entries, such as psychiatric admission assessments, physician progress notes and discharge summaries, in accordance with applicable Springfield Hospital Center policies. (Psychiatric admission assessments and discharge summaries prepared by residents are reviewed and countersigned by the supervisor before they are entered into the medical record.)
- f. Assist in the supervision of Medical Students, under the direct oversight of the resident's supervisor (see below).
- g. Order seclusion or restraint at Springfield Hospital Center, provided that this clinical activity is approved by the resident's residency training program and included in the job description for residents, as provided in writing by the training program.

**E. Residents in Professional Training Who are Currently Licensed in the State of Maryland and Who Have Applied For and Received Medical Staff Membership and Privileges to Practice as a Licensed Independent Practitioner at Springfield Hospital Center:**

These individuals are subject to the credentialing provisions of the Medical Staff Bylaws and enjoy only those rights and privileges granted by the SHC Governing Body, through the Medical Staff of Springfield Center.

## **F. Medical/Physician Assistant Students:**

1. Qualifications: In order to participate as a medical/physician assistant student in professional training at Springfield Hospital Center, the medical/physician assistant student must have the following qualifications: He/she must be a currently matriculating student in a medical/physician assistant school/program with which Springfield Hospital Center maintains a current agreement to provide clinical experiences to students of the school/program. Medical/Physician Assistant Students must be currently in good standing with the medical/physician assistant school/program. Satisfaction of this condition must be verified in writing by the medical/physician assistant school/program.
2. Supervision: Medical/physician assistant students at Springfield Hospital Center shall be supervised by an active Member of the Medical Staff, who is a licensed independent practitioner. This may be done with or without the assistance of a psychiatric resident.
  - a. The supervisor may delegate specific aspects of a medical/physician assistant student's supervision to a resident, provided that the supervisor finds that the resident is adequately prepared to provide this service, and provided that the supervisor continue to provide direct oversight to the student.
  - b. The supervising Member of the Medical Staff shall have current privileges to admit patients to Springfield Hospital Center; provide comprehensive psychiatric assessments and treatment plans; treat common psychiatric illnesses; assign psychiatric diagnoses; and provide psychiatric consultation to non-psychiatrist colleagues.
  - c. The supervisor shall be appointed to these supervisory duties by the Clinical Director in consultation with the Medical Staff President. The supervisor's performance as a supervisor shall be assessed at least annually usually as part of the supervisor's annual evaluation.
  - d. Supervisors of a medical/physician assistant student shall thoroughly assess the preparedness of the medical/physician assistant student for progressive involvement in specific patient care activities (consistent with the approved activities identified below). This assessment process is accomplished by the supervisor through regular and timely supervisory meetings with the medical/physician assistant student and, if certain supervisory duties are delegated to a resident, with the resident. During these meetings, the cases assigned to the medical/physician assistant student are thoroughly reviewed by the supervisor to assure that the clinical services that are provided by the medical/physician assistant student are medically necessary and appropriate. Written evaluations of the student's level of competency and preparedness for progression in training will be completed by the supervisor and provided to the student and to the director of student's training program midway through the student's rotation at SHC as well as upon completion of the rotation. In addition, the supervisor also assures that services provided by the

medical/physician assistant student are appropriate through regular and timely face-to-face contact with all patients assigned to the medical/physician assistant student; and through regular and timely review of the medical record of each of the cases assigned to the medical/physician assistant student. The supervisor shall have the authority to modify, suspend, or revoke all or part of the student's roles, responsibilities, and patient care activities in the event that the supervisor reasonably determines that the student has proven ill-prepared to provide those services. In such instances, the supervisor promptly provides feedback to the clinical coordinator/director of the PA program, or the director of medical student education. Feedback will also be promptly provided to Springfield Hospital Center's clinical director, and the Medical Staff Executive Committee.

- e. In the absence of the assigned supervisor another active Member of the medical staff will be designated.

3. Roles, Responsibilities and Patient Care Activities of Medical/Physician Assistant Students: Under the careful oversight of the supervisor, medical/physician assistant students may:

- a. Participate in psychiatric evaluations of newly admitted patients (after the patient has been evaluated and admitted by a Member of the Medical Staff with privileges to admit patients). While the medical/physician assistant student's assessment of a patient may contribute to the available clinical data, the student's assessment can never substitute for a full evaluation performed and documented by a Member of the Medical Staff.
- b. Accept and transcribe non-medication verbal orders by an attending physician or by a resident, provided that the medical/physician assistant student's supervisor has assessed the student's skills and determined that he/she is adequately prepared to provide this service. All verbal orders must be identified as such by the medical/physician assistant student on the order sheets and must be verified by countersignature by the ordering physician on the same day. NOTE: Under no circumstance may a medical/physician assistant student independently issue a medication or non-medication order.
- c. Meet privately with patients and their families in order to gather clinical data and participate in individual, group and family therapies and interventions under the supervision of a resident or a supervising attending physician. These services may only be provided by a medical/physician assistant student after the supervisor has assessed the student's skills and determined that he/she is adequately prepared to provide these services.
- d. Participate with the attending physician in the creation and implementation of the patient's Individual Plan of Care (IPOC).
- e. With the permission of the attending physician, write and enter psychiatric assessments and progress notes. These assessments and

progress notes must be countersigned by the supervising attending physician or by the resident.

- f. NOTE: progress notes and other medical record entries made by a medical/physician assistant student may never substitute for medical record entries that are required of attending physicians or residents by Springfield Hospital Center policy and procedure. Instead, these entries are made in addition to the documentation that is required of the attending physician or resident.

Initiated September 19, 2002; Rev: September 2003  
Reviewed: September 2005; Revised: January 2007  
Revised: May 2009; Approved: September 2009  
Revised: May 2014

# SPRINGFIELD HOSPITAL CENTER

## MEDICAL STAFF BYLAWS

### SIGNATURE PAGE

#### APPROVED:

\_\_\_\_\_  
Signature on File  
**President, Medical Staff**

\_\_\_\_\_  
9/2/2014  
**Date**

\_\_\_\_\_  
Signature on File  
**Clinical Director**

\_\_\_\_\_  
9/2/2014  
**Date**

\_\_\_\_\_  
Signature on File  
**Chief Executive Officer**

\_\_\_\_\_  
9/2/2014  
**Date**

\_\_\_\_\_  
Signature on File  
**Chairperson, SHC Executive Council**

\_\_\_\_\_  
9/2/2014  
**Date**

Adopted: March 2000  
Revised: October 2003  
Revised: September 2005  
Revised: January 2007  
Revised: September 2007  
Revised: May 2008  
Revised: September 2008  
Revised: May 2009; Approved September 2009  
Revised: May 2011; Approved: June 2011  
Revised: May 2012; Approved: July 2012  
Revised: December 2012; Approved: January 2013  
Revised: May 2014; Approved: July 2014